

FitzPatrick

Initiating Events



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)

Inspection Report# : [2000003\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)

Mitigating Systems



Significance: Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)

W

Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [2000008\(pdf\)](#)Inspection Report# : [1999009\(pdf\)](#)Inspection Report# : [2000001\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO₂) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO₂ suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure

pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPCI system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)



Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)

G

Significance: Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMs PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)

G

Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 4OA5.4)

Inspection Report# : [2000006\(pdf\)](#)

G

Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)

G

Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2000005\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the the allowable out of service time in the TSs. The NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER

The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER

When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify

and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYPA performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety- related station battery busses. NYPA's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)

G

Significance: Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)

Barrier Integrity

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.
Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFT

Inspection Report# : [2001010\(pdf\)](#)

G

Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TTESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runoff condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory.

Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the

SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SGBT SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

Emergency Preparedness

G

Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified. (Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air

cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: G Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)

Public Radiation Safety

G

Significance: G Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involve package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection

G

Significance: G Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither

predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : April 01, 2002

FitzPatrick

Initiating Events

G**Significance:** May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)G**Significance:** May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)

Inspection Report# : [2000003\(pdf\)](#)G**Significance:** Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems

G**Significance:** May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER

When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER

The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)

G

Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYPAs performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety-related station battery busses. NYPAs's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)

G

Significance: Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)

W

Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [1999009\(pdf\)](#)Inspection Report# : [2000001\(pdf\)](#)Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)

G**Significance:** Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)G**Significance:** Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO₂) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO₂ suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)G**Significance:** Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)G**Significance:** Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)G**Significance:** Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure

pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPCI system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)



Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMs PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 4OA5.4)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2000005\(pdf\)](#)



Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

Barrier Integrity

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SGBT SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFTInspection Report# : [2001010\(pdf\)](#)

G

Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)



Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory.

Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

Emergency Preparedness



Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified.

(Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus

(SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: G Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)

Public Radiation Safety



Significance: G Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involve package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection



Significance: G Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : April 01, 2002

FitzPatrick

Initiating Events



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)

Inspection Report# : [2000003\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems



Significance: Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of

NRC requirements. (Section 1R22)
 Inspection Report# : [2000006\(pdf\)](#)

G

Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)
 Inspection Report# : [2000006\(pdf\)](#)

G

Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)
 Inspection Report# : [2000005\(pdf\)](#)

G

Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)
 Inspection Report# : [2000005\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)
 Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual

heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)
Inspection Report# : [2000004\(pdf\)](#)



Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)



Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the the allowable out of service time in the TSs. The NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER

The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER

When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYP&A performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety-related station battery busses. NYP&A's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant

safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)



Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [2000001\(pdf\)](#)

Inspection Report# : [1999009\(pdf\)](#)

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violaiton. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO2) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO2 suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 40A4.4)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation.

However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)**Significance: N/A** Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the

system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)

G

Significance: Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPCI system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity

G

Significance: Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory.

Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SGBT SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 4OA4.1)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFTInspection Report# : [2001010\(pdf\)](#)

G

Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TESTING FAILURES OF MAIN STEAM

ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness

G

Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified.

(Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

G

Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: G Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Public Radiation Safety



Significance: G Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involve package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection



Significance: G Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : March 29, 2002

FitzPatrick

Initiating Events



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)

Inspection Report# : [2000003\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems



Significance: Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions

did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2000005\(pdf\)](#)



Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER

The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER

When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at

the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYPA performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety- related station battery busses. NYPA's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)

G

Significance: Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)

G

Significance: Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Emergency failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too

short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)
Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and

did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [2000001\(pdf\)](#)

Inspection Report# : [1999009\(pdf\)](#)

Inspection Report# : [2000008\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO₂) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO₂ suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-

maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPIC SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPIC system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity

G

Significance: Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory. Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SGBT SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)

G

Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFTInspection Report# : [2001010\(pdf\)](#)

G

Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness

G

Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified.

(Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

G

Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: G Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Public Radiation Safety



Significance: G Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involve package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection



Significance: G Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : March 28, 2002

FitzPatrick

Initiating Events



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)
Inspection Report# : [2000003\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight.

Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC

requirements. (Section 1R19)
Inspection Report# : [2000005\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The

NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER

The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER

When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYPAs performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety-related station battery busses. NYPAs's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)

G

Significance: Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [2000008\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [1999009\(pdf\)](#)

Inspection Report# : [2000001\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 40A4.4)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO₂) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO₂ suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure

pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPCI system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity



Significance: Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory.

Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SGBT SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFT

Inspection Report# : [2001010\(pdf\)](#)

G

Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness

G

Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified.

(Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or

subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mR/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.
Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Public Radiation Safety

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involve package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to

be a non-cited violation. (Section 2PS2)
Inspection Report# : [1999008\(pdf\)](#)

Physical Protection



Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : March 28, 2002

FitzPatrick

Initiating Events



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)

Inspection Report# : [2000003\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems



Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would

not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)
Inspection Report# : [2001004\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

G

Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate.

These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)

G

Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2000005\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation.

However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive

(CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The

NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER

The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER

When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYPA performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety-related station battery busses. NYPA's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)



Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)

W

Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scram HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [1999009\(pdf\)](#)Inspection Report# : [2000001\(pdf\)](#)Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violaiton. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO₂) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO₂ suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered

unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPCI system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity

G

Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TTESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory.

Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFTInspection Report# : [2001010\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SGBT SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)

G

Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness



Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified. (Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace

period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Public Radiation Safety



Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involved package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection



Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : March 27, 2002

FitzPatrick

Initiating Events



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)
Inspection Report# : [2000003\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC

requirements. (Section 1R15)
 Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)



Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight.

Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC

requirements. (Section 1R19)
 Inspection Report# : [2000005\(pdf\)](#)



Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)



Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)



Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)



Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The

NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER

The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER

When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.

Inspection Report# : [2000007\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYPA performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety- related station battery busses. NYPA's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)



Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [1999009\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [2000008\(pdf\)](#)

Inspection Report# : [2000001\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)

G**Significance:** Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)G**Significance:** Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO₂) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO₂ suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)G**Significance:** Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)G**Significance:** Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)G**Significance:** Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure

pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPCI system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity



Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFTInspection Report# : [2001010\(pdf\)](#)

G

Significance: Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory. Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTs.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SBTG SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness

Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified.

(Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance

because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: G Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)

G

Significance: G Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Public Radiation Safety

G

Significance: G Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involve package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection



Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : March 26, 2002

FitzPatrick

Initiating Events

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)
Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)
Inspection Report# : [2000003\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)
Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)
Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)
Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety

significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of

NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)G**Significance:** Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)

Inspection Report# : [2000006\(pdf\)](#)G**Significance:** Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not.

Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)G**Significance:** Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2000005\(pdf\)](#)G**Significance:** Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)G**Significance:** Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER

The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).

Inspection Report# : [2000007\(pdf\)](#)

G

Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Inspection Report# : [2000007\(pdf\)](#)

G**Significance:** Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.

Inspection Report# : [2000007\(pdf\)](#)G**Significance:** Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER

When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)

Inspection Report# : [2000007\(pdf\)](#)G**Significance:** Apr 13, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)

Inspection Report# : [2000007\(pdf\)](#)G**Significance:** Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYPAs performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety-related station battery busses. NYPAs's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)G**Significance:** Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)

G

Significance: Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)

G

Significance: Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)

W

Significance: Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [2000008\(pdf\)](#)Inspection Report# : [1999009\(pdf\)](#)Inspection Report# : [2000001\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)

G

Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI

inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violaiton. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO2) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO2 suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-

accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPIC system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity



Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFT

Inspection Report# : [2001010\(pdf\)](#)



Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

G**Significance:** Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)G**Significance:** Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory.

Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)G**Significance:** May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)G**Significance:** May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SGBT SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)G**Significance:** Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)G**Significance:** Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC

requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness



Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified.

(Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Public Radiation Safety

G

Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involve package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection

G

Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any

hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : March 01, 2002

FitzPatrick

Initiating Events



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)

Inspection Report# : [2000003\(pdf\)](#)



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control

system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)
Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)



Significance: Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)



Significance: May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged

from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.
Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)



Significance: Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

**Significance:** Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)**Significance:** Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)**Significance:** Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)

Inspection Report# : [2000006\(pdf\)](#)**Significance:** Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)**Significance:** Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2000005\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

G

Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)

G

Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)**Significance:** Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01 above). When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01 above)

Inspection Report# : [2000007\(pdf\)](#)**Significance:** Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program. A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02 above)

Inspection Report# : [2000007\(pdf\)](#)**Significance:** Apr 01, 2000

Identified By: NRC
Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYPA performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety-related station battery busses. NYPA's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Apr 01, 2000

Identified By: NRC
Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)



Significance: Feb 19, 2000

Identified By: NRC
Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)



Significance: Jan 08, 2000

Identified By: NRC
Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC
Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify

the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [1999009\(pdf\)](#)

Inspection Report# : [2000001\(pdf\)](#)

Inspection Report# : [2000008\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)



Significance: Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violaiton. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO2) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative

assumption for medium degradation of the automatic CO2 suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPAs reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPAs determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)



Significance: Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPCI system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity

Significance: Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFT

Inspection Report# : [2001010\(pdf\)](#)



Significance: Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)



Significance: Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

**Significance:** Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory. Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)**Significance:** May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)**Significance:** May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SBTG SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)**Significance:** Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)**Significance:** Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness

G

Significance: Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified. (Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

G

Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)**Significance:** N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mR/hr and the individuals were in the area for less than 15 minutes.

This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Public Radiation Safety



Significance: Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involve package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection



Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous



Significance: Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE PREVENTIVE MAINTENANCE OF THE STARTUP FEEDWATER CONTROL VALVE.

The inspectors identified that preventive maintenance performed on a startup feedwater control valve was inadequate and that two functional failures of the valve had not been properly categorized in accordance with 10 CFR 50.65. This issue was considered more than minor, because failure of the valve to control feedwater flow to the reactor vessel could result in a loss of feedwater transient and plant trip. However, this issue was determined to be of very low safety significance using phase one of the SDP because it did not contribute to the likelihood of a LOCA initiator or of both a reactor trip and unavailability of mitigating equipment, and did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2002003\(pdf\)](#)



Significance: Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTION FOR SAFETY-RELATED TEMPERATURE CONTROL VALVES.

The inspectors identified a longstanding uncorrected condition adverse to quality involving inability to perform inservice tests of four control room/relay room temperature control valves. The issue was considered more than minor, because longstanding uncorrected problems involving accident mitigating equipment could become a more significant safety concern. However, this issue was determined to be of very low safety significance using phase one of the SDP because the failed open valves were in the accident mitigating position and represented a design deficiency that was confirmed not to result in a loss of safety function per Generic Letter 91-18, Revision 1.

Inspection Report# : [2002003\(pdf\)](#)



Significance: Feb 09, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

THE FAILURE TO ADEQUATELY REVIEW A DESIGN CHANGE IMPLEMENTED BY A TEMPORARY MODIFICATION.

The inspectors identified that a temporary modification to install a data recorder to the B reactor water recirculation pump motor generator speed control circuit was inadequate. The temporary modification failed to address seismic concerns with the control room cabinet door that could have resulted in an inadvertent plant transient. The cabinet door was left open due to the protruding wires and was not restrained. This issue was considered more than minor because of the potential for a plant transient if the door were to close on the protruding wires. However, this issue was determined to be of very low safety significance using phase one of the SDP because the modification would not cause the failure of any mitigation systems. This issue was considered a non-cited violation of NRC requirements.

Inspection Report# : [2001013\(pdf\)](#)

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

P&IR SUMMARY FINDING & FITZPATRICK STAFF FAMILIARITY WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The findings from this inspection were consistent with issues identified by inspection reports over the course of the last year. NYPA continues to be challenged with implementation of the corrective action program at FitzPatrick. Specific areas of concern include ineffective tracking of corrective actions to ensure completion, insufficient problem evaluation, and recurring equipment performance deficiencies due to inadequate corrective actions. Although the findings identified during this inspection were of very low safety significance, the concerns noted above have previously contributed to degraded conditions with the high pressure coolant injection system, the reactor core isolation cooling system, the emergency service water system, and the reactor protection system electrical protection assemblies. The FitzPatrick self-assessments and external reviews were consistent with the inspection findings. During the inspection, FitzPatrick management approved the report of an internal "Common Cause Analysis" of the corrective action program. The team found this report to be extensive and critical. As a result of the Common Cause Analysis, FitzPatrick developed an "Action Plan for Improvement of the Corrective Action Program." Continued NYPA management attention is warranted to ensure these proposed actions are effective in improving the station performance in the problem identification and resolution (P&IR) area. The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)**Significance: SL-IV** Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)**Significance: SL-IV** Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : July 22, 2002

FitzPatrick

Initiating Events

Significance:  Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE PREVENTIVE MAINTENANCE OF THE STARTUP FEEDWATER CONTROL VALVE.

The inspectors identified that preventive maintenance performed on a startup feedwater control valve was inadequate and that two functional failures of the valve had not been properly categorized in accordance with 10 CFR 50.65. This issue was considered more than minor because failure of the valve to control feedwater flow to the reactor vessel could result in a loss of feedwater transient and plant trip. However, this issue was determined to be of very low safety significance using phase one of the SDP because it did not contribute to the likelihood of a LOCA initiator or of both a reactor trip and unavailability of mitigating equipment, and did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2002003\(pdf\)](#)

Significance:  Feb 09, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

THE FAILURE TO ADEQUATELY REVIEW A DESIGN CHANGE IMPLEMENTED BY A TEMPORARY MODIFICATION.

The inspectors identified that a temporary modification to install a data recorder to the B reactor water recirculation pump motor generator speed control circuit was inadequate. The temporary modification failed to address seismic concerns with the control room cabinet door that could have resulted in an inadvertent plant transient. The cabinet door was left open due to the protruding wires and was not restrained. This issue was considered more than minor because of the potential for a plant transient if the door were to close on the protruding wires. However, this issue was determined to be of very low safety significance using phase one of the SDP because the modification would not cause the failure of any mitigation systems. This issue was considered a non-cited violation of NRC requirements.

Inspection Report# : [2001013\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems

Significance:  Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2001009\(pdf\)](#)

Significance:  Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test.

Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)

Significance:  Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)

Significance:  Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)

Significance:  May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)

Significance:  Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)

Significance:  Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

Significance:  Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

Significance:  Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

Significance:  Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)

Significance:  Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO

CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)

Inspection Report# : [2000006\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)



Significance: Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance

test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2000005\(pdf\)](#)

Significance:  Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)

Significance:  Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

Significance:  Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)



Significance: May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)



Significance: Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01 above). When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were

satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01 above)
Inspection Report# : [2000007\(pdf\)](#)

Significance:  Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program. A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02 above)

Inspection Report# : [2000007\(pdf\)](#)

Significance:  Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYP&A performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety-related station battery busses. NYP&A's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)

Significance:  Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications,

such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)

Significance:  Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)

Significance:  Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)

Significance:  Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not

issued. (Final Significance Determination)

Inspection Report# : [1999009\(pdf\)](#)

Inspection Report# : [2000001\(pdf\)](#)

Inspection Report# : [2000008\(pdf\)](#)

Significance:  Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)

Significance:  Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violaiton. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO₂) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO₂ suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)



Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPCI system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity

Significance:  Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFT

Technical Specifications 3.2.G, Table 3.2-7, Note 3, which requires that the high reactor pressure ATWS recirculation pump trip setpoint be lowered when two or more safety relief valves are out of service, was not satisfied during operating cycle 14. This issue was evaluated using the SDP and determined to be of very low safety significance (Green). The event was addressed in the licensee's corrective action program in DER 01-02396. This issue is being treated as a licensee-identified Non-Cited Violation.

Inspection Report# : [2001010\(pdf\)](#)

Significance:  Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

Significance:  Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

Significance:  Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the

torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory. Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SBTG SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness

Significance:  Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified. (Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

Significance:  Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

Significance:  Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)

Significance:  Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Public Radiation Safety

Significance:  Jun 03, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Used Resin Shipment Exceeded Free Standing Liquid Limits

The inspector identified a non-cited violation of 10 CFR 61.56(b)(2) having very low safety significance. On June 3, 2002, Entergy failed to assure that a spent resin waste container, received for disposal at the Chem-Nuclear Low Level Waste Disposal Facility in Barnwell, South Carolina, contained less than the allowable limit for free-standing liquid. Entergy's failure to assure that the spent resin shipped for disposal met the de-watering criteria was determined to have very low safety significance using the Public Radiation Safety Significance Determination Process. The finding involved radioactive material control relative to non-conformance with pertinent waste characteristic specifications required for radioactive waste materials tendered for disposal at a licensed waste disposal facility. In this case, the conformance issue was not significant enough to result in denial of access to the disposal facility; and no other issues involving transportation requirements, such as package integrity, Certificate of Compliance, or radiation limits were involved.

Inspection Report# : [2002005\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involved package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection



Significance: Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

P&IR SUMMARY FINDING & FITZPATRICK STAFF FAMILIARITY WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The findings from this inspection were consistent with issues identified by inspection reports over the course of the last year. NYPA continues to be challenged with implementation of the corrective action program at FitzPatrick. Specific areas of concern include ineffective tracking of corrective actions to ensure completion, insufficient problem evaluation, and recurring equipment performance deficiencies due to inadequate corrective actions. Although the findings identified during this inspection were of very low safety significance, the concerns noted above have previously contributed to degraded conditions with the high pressure coolant injection system, the reactor core isolation cooling system, the emergency service water system, and the reactor protection system electrical protection assemblies. The FitzPatrick self-assessments and external reviews were consistent with the inspection findings. During the inspection, FitzPatrick management approved the report of an internal "Common Cause Analysis" of the corrective action program. The team found this report to be extensive and critical. As a result of the Common Cause Analysis, FitzPatrick developed an "Action Plan for Improvement of the Corrective Action Program." Continued NYPA management attention is warranted to ensure these proposed actions are effective in improving the station performance in the problem identification and resolution (P&IR) area. The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to

a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : August 29, 2002

FitzPatrick

Initiating Events

Significance:  Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE PREVENTIVE MAINTENANCE OF THE STARTUP FEEDWATER CONTROL VALVE.

The inspectors identified that preventive maintenance performed on a startup feedwater control valve was inadequate and that two functional failures of the valve had not been properly categorized in accordance with 10 CFR 50.65. This issue was considered more than minor because failure of the valve to control feedwater flow to the reactor vessel could result in a loss of feedwater transient and plant trip. However, this issue was determined to be of very low safety significance using phase one of the SDP because it did not contribute to the likelihood of a LOCA initiator or of both a reactor trip and unavailability of mitigating equipment, and did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2002003\(pdf\)](#)

Significance:  Feb 09, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

THE FAILURE TO ADEQUATELY REVIEW A DESIGN CHANGE IMPLEMENTED BY A TEMPORARY MODIFICATION.

The inspectors identified that a temporary modification to install a data recorder to the B reactor water recirculation pump motor generator speed control circuit was inadequate. The temporary modification failed to address seismic concerns with the control room cabinet door that could have resulted in an inadvertent plant transient. The cabinet door was left open due to the protruding wires and was not restrained. This issue was considered more than minor because of the potential for a plant transient if the door were to close on the protruding wires. However, this issue was determined to be of very low safety significance using phase one of the SDP because the modification would not cause the failure of any mitigation systems. This issue was considered a non-cited violation of NRC requirements.

Inspection Report# : [2001013\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.

A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.

During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.

The reactor water level control system has been operated in single element control mode, vice three element control mode as specified in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)

Inspection Report# : [1999009\(pdf\)](#)

Mitigating Systems

Significance:  Aug 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to identify that the "B" ESW pump was inoperable after results of a TS required surveillance test were less than the value in TSSR 3.11.D

A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because licensee personnel failed to identify that, during a surveillance test, the "B" emergency service water (ESW) pump was inoperable after the flow for the "B" train of ESW was below the required value in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the licensee had erroneously concluded that the pump was operable based on a non-safety system cooled by the "B" train of ESW being tagged out of service. This finding is greater than minor and could become a more significant safety concern because operators failed to recognize inoperable equipment during surveillance testing. The ESW system provides cooling water to the emergency diesel generators (EDGs) and the room coolers for the emergency core cooling system (ECCS) pumps. The failure of ESW is applicable to the mitigating systems cornerstone, because the failure of the ESW system could affect the safety function of the EDGs and/or the ECCS pumps. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the low flow condition for the "B" ESW pump was not of significant magnitude to preclude the system from meeting its safety function. (Section 40A2.b(2)(a))

Inspection Report# : [2002006\(pdf\)](#)

Significance:  Aug 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate operability evaluation for suspect Agastat timers resulted in failure to promptly identify failed timer for the "D" RHR pump

A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because FitzPatrick personnel failed to adequately evaluate the operability of the emergency diesel generator (EDG) Agastat sequence timers controlling the residual heat removal (RHR) pumps. The RHR timers were of the same type and surveillance frequency as the core spray (CS) timers which had failed their Technical Specification required surveillance test. When the RHR timers were tested, the "D" RHR pump timer failed to meet the value listed in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the FitzPatrick basis for operability failed to recognize that the surveillance frequency for the RHR timers had been extended from 6 months to 24 months, a contributing factor for the CS timers failing. This finding is greater than minor and could have become a more significant safety concern because personnel failed to perform adequate operability determinations for suspect conditions adverse to quality. The Agastat timers are used to sequence emergency equipment and system loads onto the EDGs at pre-determined intervals, in order to minimize the potential for damage to the EDGs. The failure of an RHR Agastat timer for the EDG sequencer timer is applicable to the mitigating systems cornerstone, because the failure of timers could result in multiple loads sequencing onto the EDG at the same time, which could affect the reliability of the EDGs or the loads supplied by the EDGs. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the out-of-tolerance condition for the "D" RHR pump timer was not of significant magnitude to preclude the system from meeting its safety function. (Section 40A2.b(2)(b))

Inspection Report# : [2002006\(pdf\)](#)

Significance:  Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.

Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2001009\(pdf\)](#)

Significance:  Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST-MAINTENANCE TESTS.

The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test.

Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2001009\(pdf\)](#)

Significance:  Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.

The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2001009\(pdf\)](#)

Significance:  Sep 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.

Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.

Inspection Report# : [2001009\(pdf\)](#)

Significance:  May 19, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.

The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)

Inspection Report# : [2001004\(pdf\)](#)

Significance:  Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.

The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight. Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).

Inspection Report# : [2001003\(pdf\)](#)

Significance:  Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.

Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.

Inspection Report# : [2001003\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME

Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)

Significance:  Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

Significance:  Feb 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.

Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not

adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.

Inspection Report# : [2000013\(pdf\)](#)

Significance:  Nov 18, 2000

Identified By: NRC

Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.

The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adequately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requirements was identified. (Section 1R15).

Inspection Report# : [2000009\(pdf\)](#)

Significance:  Sep 30, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.

During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000006\(pdf\)](#)

Significance:  Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.

NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 40A5.4)

Inspection Report# : [2000006\(pdf\)](#)

Significance:  Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.

During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)

Inspection Report# : [2000005\(pdf\)](#)

Significance:  Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.

Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC requirements. (Section 1R19)

Inspection Report# : [2000005\(pdf\)](#)

Significance:  Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.

The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000004\(pdf\)](#)

Significance:  Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.

The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was

later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)

Inspection Report# : [2000004\(pdf\)](#)

Significance:  Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.

The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)

Inspection Report# : [2000004\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.

Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requirements. (Section 1R15)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  May 05, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999

NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the allowable out of service time in the TSs. The NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.

Inspection Report# : [2000008\(pdf\)](#)

Significance:  Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.

On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the

procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance criteria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01 above). When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01 above)

Inspection Report# : [2000007\(pdf\)](#)

Significance:  Apr 13, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER

A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program. A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02 above)

Inspection Report# : [2000007\(pdf\)](#)

Significance:  Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM

NYP&A performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety-related station battery busses. NYP&A's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was

identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.

Inspection Report# : [2000002\(pdf\)](#)

Significance:  Apr 01, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS

The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.

Inspection Report# : [2000002\(pdf\)](#)

Significance:  Feb 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.

The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.

Inspection Report# : [2000001\(pdf\)](#)

Significance:  Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.

Two examples of a non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.

Inspection Report# : [1999010\(pdf\)](#)

Significance:  Nov 27, 1999

Identified By: NRC

Item Type: VIO Violation

HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.

As demonstrated during the post-scrum HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating

pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)

Inspection Report# : [1999009\(pdf\)](#)

Inspection Report# : [2000001\(pdf\)](#)

Inspection Report# : [2000008\(pdf\)](#)

Significance:  Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)

Inspection Report# : [1999009\(pdf\)](#)

Significance:  Nov 27, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.

The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not required by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R19)

Inspection Report# : [1999009\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.

The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system

inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. This issue was determined to be a non-cited violation. (Section 1R03)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.

Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO2) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO2 suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.

The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.

NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Aug 28, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.

The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.

Inspection Report# : [1999007\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES

The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INITIATE A DEFICIENCY REPORT

Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.

Inspection Report# : [1999006\(pdf\)](#)

G

Significance: Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM

The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPIC system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Barrier Integrity

Significance:  Nov 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

SAFETY RELIEF VALVE SETPOINT DRIFT

Technical Specifications 3.2.G, Table 3.2-7, Note 3, which requires that the high reactor pressure ATWS recirculation pump trip setpoint be lowered when two or more safety relief valves are out of service, was not satisfied during operating cycle 14. This issue was evaluated using the SDP and determined to be of very low safety significance (Green). The event was addressed in the licensee's corrective action program in DER 01-02396. This issue is being treated as a licensee-identified Non-Cited Violation.

Inspection Report# : [2001010\(pdf\)](#)

Significance:  Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TTESTING FAILURES OF MAIN STEAM ISOLATION VALVES

The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.

Inspection Report# : [2001005\(pdf\)](#)

Significance:  Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM POST-MAINTENANCE TESTING.

A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.

Inspection Report# : [2000011\(pdf\)](#)

Significance:  Jul 18, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.

NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory. Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000004\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SGBT SYSTEM.

NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)

Inspection Report# : [2000003\(pdf\)](#)

Significance:  Jan 08, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.

On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.

Inspection Report# : [1999010\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.

NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 40A4.1)

Inspection Report# : [1999008\(pdf\)](#)

Significance:  Jul 17, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE

The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.

Inspection Report# : [1999006\(pdf\)](#)

Emergency Preparedness

Significance:  Sep 30, 2000

Identified By: NRC

Item Type: FIN Finding

TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.

Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified. (Section 1EP6)

Inspection Report# : [2000006\(pdf\)](#)

Occupational Radiation Safety

Significance:  Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.

A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.

Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or subsequently contacting the radiation protection department upon receiving electronic dosimetry dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.

Inspection Report# : [2001003\(pdf\)](#)



Significance: G Sep 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.

The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)

Inspection Report# : [2000006\(pdf\)](#)



Significance: G Jul 17, 1999

Identified By: NRC

Item Type: FIN Finding

CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE

The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.

Inspection Report# : [1999006\(pdf\)](#)

Significance:  Jun 03, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Used Resin Shipment Exceeded Free Standing Liquid Limits

The inspector identified a non-cited violation of 10 CFR 61.56(b)(2) having very low safety significance. On June 3, 2002, Entergy failed to assure that a spent resin waste container, received for disposal at the Chem-Nuclear Low Level Waste Disposal Facility in Barnwell, South Carolina, contained less than the allowable limit for free-standing liquid. Entergy's failure to assure that the spent resin shipped for disposal met the de-watering criteria was determined to have very low safety significance using the Public Radiation Safety Significance Determination Process. The finding involved radioactive material control relative to non-conformance with pertinent waste characteristic specifications required for radioactive waste materials tendered for disposal at a licensed waste disposal facility. In this case, the conformance issue was not significant enough to result in denial of access to the disposal facility; and no other issues involving transportation requirements, such as package integrity, Certificate of Compliance, or radiation limits were involved.

Inspection Report# : [2002005\(pdf\)](#)

Significance:  Oct 18, 1999

Identified By: NRC

Item Type: NCV NonCited Violation

THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.

A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involved package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to be a non-cited violation. (Section 2PS2)

Inspection Report# : [1999008\(pdf\)](#)

Physical Protection

Significance:  Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING

A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).

Inspection Report# : [2000002\(pdf\)](#)

Miscellaneous

Significance: N/A Aug 11, 2000

Identified By: NRC

Item Type: FIN Finding

P&IR SUMMARY FINDING & FITZPATRICK STAFF FAMILIARITY WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.

The findings from this inspection were consistent with issues identified by inspection reports over the course of the last year. NYPA continues to be challenged with implementation of the corrective action program at FitzPatrick. Specific areas of concern include ineffective tracking of corrective actions to ensure completion, insufficient problem evaluation, and recurring equipment performance deficiencies due to inadequate corrective actions. Although the findings identified during this inspection were of very low safety significance, the concerns noted above have previously contributed to degraded conditions with the high pressure coolant injection system, the reactor core isolation cooling system, the emergency service water system, and the reactor protection system electrical protection assemblies. The FitzPatrick self-assessments and external reviews were consistent with the inspection findings. During the inspection, FitzPatrick management approved the report of an internal "Common Cause Analysis" of the corrective action program. The team found this report to be extensive and critical. As a result of the Common Cause Analysis, FitzPatrick developed an "Action Plan for Improvement of the Corrective Action Program." Continued NYPA management attention is warranted to ensure these proposed actions are effective in improving the station performance in the problem identification and resolution (P&IR) area. The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.

A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.

A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Significance: SL-IV Aug 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.

A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

Inspection Report# : [2000011\(pdf\)](#)

Last modified : December 02, 2002

FitzPatrick

Initiating Events



Significance: Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate preventive maintenance of the startup feedwater control valve resulted in a violation of 10 CFR 50.65, "Maintenance Rule."

The inspectors identified that preventive maintenance performed on a startup feedwater control valve was inadequate and that two functional failures of the valve had not been properly categorized in accordance with 10 CFR 50.65. This issue was considered more than minor because failure of the valve to control feedwater flow to the reactor vessel could result in a loss of feedwater transient and plant trip. However, this issue was determined to be of very low safety significance using phase one of the SDP because it did not contribute to the likelihood of a LOCA initiator or of both a reactor trip and unavailability of mitigating equipment, and did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2002003\(pdf\)](#)



Significance: Feb 09, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

The failure to adequately review a design change implemented by a temporary modification resulted in a violation of 10CFR 50 Appendix B Criterion III.

The inspectors identified that a temporary modification to install a data recorder to the B reactor water recirculation pump motor generator speed control circuit was inadequate. The temporary modification failed to address seismic concerns with the control room cabinet door that could have resulted in an inadvertent plant transient. The cabinet door was left open due to the protruding wires and was not restrained. This issue was considered more than minor because of the potential for a plant transient if the door were to close on the protruding wires. However, this issue was determined to be of very low safety significance using phase one of the SDP because the modification would not cause the failure of any mitigation systems. This issue was considered a non-cited violation of NRC requirements.

Inspection Report# : [2001013\(pdf\)](#)

Mitigating Systems



Significance: Sep 30, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

The use of inadequate engineering analysis to extend the surveillance interval for the CS and RHR pump timer relays was a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control."

Entergy failed to follow engineering procedure guidance for an analysis of the CS and RHR pump timer relays that was performed to support extending the surveillance test interval for these relays from six months to two years. The engineering procedure required that because the span of the available instrument drift data was not large enough to cover the proposed new test interval, instrument drift for this analysis must be assumed to be time dependent; however, Entergy's analysis erroneously assumed that the timer relay drift values were time independent. This issue had a credible impact on safety because failure of the relays to operate within the TS time limits could delay the injection of water to the reactor during a LOCA. The inspector determined this issue to be of very low safety significance because it did not result in an actual loss of safety function for the CS and RHR systems.

Inspection Report# : [2002007\(pdf\)](#)



Significance: Aug 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to identify that the "B" ESW pump was inoperable after results of a TS required ST were less than the TSSR 3.11.D acceptance criteria was a violation of 10CFR50 Appendix B Criterion XVI.

A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because licensee personnel failed to identify that, during a surveillance test, the "B" emergency service water (ESW) pump was inoperable after the flow for the "B" train of ESW was below the required value in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the licensee had erroneously concluded that the pump was operable based on a non-safety system cooled by the "B" train of ESW being tagged out of service. This finding is greater than minor and could become a more significant safety concern because operators failed to recognize inoperable equipment during surveillance testing. The ESW system provides cooling water to the emergency diesel generators (EDGs) and the room coolers for the emergency core cooling system (ECCS) pumps. The failure of ESW is applicable to the mitigating systems cornerstone, because the failure of the ESW system could affect the safety function of the EDGs and/or the ECCS pumps. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the low flow condition for the "B" ESW pump was not of significant magnitude to preclude the system from meeting its safety function. (Section 40A2.b(2)(a))

Inspection Report# : [2002006\(pdf\)](#)



Significance: Aug 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate operability evaluation for suspect agastat timers resulted in failure to promptly identify failed timer for the "D" RHR pump and a violation of 10CFR50 Appendix B Criterion XVI.

A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because FitzPatrick personnel failed to adequately evaluate the operability of the emergency diesel generator (EDG) Agastat sequence timers controlling the residual heat removal (RHR) pumps. The RHR timers were of the same type and surveillance frequency as the core spray (CS) timers which had failed their Technical Specification required surveillance test. When the RHR timers were tested, the "D" RHR pump timer failed to meet the value listed in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the FitzPatrick basis for operability failed to recognize that the surveillance frequency for the RHR timers had been extended from 6 months to 24 months, a contributing factor for the CS timers failing. This finding is greater than minor and could have become a more significant safety concern because personnel failed to perform adequate operability determinations for suspect conditions adverse to quality. The Agastat timers are used to sequence emergency equipment and system loads onto the EDGs at pre-determined intervals, in order to minimize the potential for damage to the EDGs. The failure of an RHR Agastat timer for the EDG sequencer timer is applicable to the mitigating systems cornerstone, because the failure of timers could result in multiple loads sequencing onto the EDG at the same time, which could affect the reliability of the EDGs or the loads supplied by the EDGs. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the out-of-tolerance condition for the "D" RHR pump timer was not of significant magnitude to preclude the system from meeting its safety function. (Section 40A2.b(2)(b))

Inspection Report# : [2002006\(pdf\)](#)



Significance: Mar 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to identify and correct a condition adverse to quality that prevented IST of four control room/relay room temperature control valves was a violation of 10 CFR 50, Appendix B, Criterion XVI.

The inspectors identified a long-standing uncorrected condition adverse to quality involving inability to perform inservice tests of four control room/relay room temperature control valves. The issue was considered more than minor, because long-standing uncorrected problems involving accident mitigating equipment could become a more significant safety concern. However, this issue was determined to be of very low safety significance using phase one of the SDP because the failed open valves were in the accident mitigating position and represented a design deficiency that was confirmed not to result in a loss of safety function per Generic Letter 91-18, Revision 1.

Inspection Report# : [2002003\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

G

Significance: Jun 03, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Used resin shipment exceeded free standing liquid limits resulting in a violation of 10 CFR 61.56(b)(2).

The inspector identified a non-cited violation of 10 CFR 61.56(b)(2) having very low safety significance. On June 3, 2002, Entergy failed to assure that a spent resin waste container, received for disposal at the Chem-Nuclear Low Level Waste Disposal Facility in Barnwell, South Carolina, contained less than the allowable limit for free-standing liquid. Entergy's failure to assure that the spent resin shipped for disposal met the de-watering criteria was determined to have very low safety significance using the Public Radiation Safety Significance Determination Process. The finding involved radioactive material control relative to non-conformance with pertinent waste characteristic specifications required for radioactive waste materials tendered for disposal at a licensed waste disposal facility. In this case, the conformance issue was not significant enough to result in denial of access to the disposal facility; and no other issues involving transportation requirements, such as package integrity, Certificate of Compliance, or radiation limits were involved.

Inspection Report# : [2002005\(pdf\)](#)

Physical Protection

Miscellaneous

Last modified : March 25, 2003

FitzPatrick

1Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

The use of inadequate engineering analyas to extend the surveillance interval for the CS and RHR pump timer relays was a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control."

Entergy failed to follow engineering procedure guidance for an analysis of the CS and RHR pump timer relays that was performed to support extending the surveillance test interval for these relays from six months to two years. The engineering procedure required that because the span of the available instrument drift data was not large enough to cover the proposed new test interval, instrument drift for this analysis must be assumed to be time dependent; however, Entergy's analysis erroneously assumed that the timer relay drift values were time independent. This issue had a credible impact on safety because failure of the relays to operate within the TS time limits could delay the injection of water to the reactor during a LOCA. The inspector determined this issue to be of very low safety significance because it did not result in an actual loss of safety function for the CS and RHR systems.

Inspection Report# : [2002007\(pdf\)](#)

Significance:  Aug 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to identify that the "B" ESW pump was inoperable after results of a TS required ST were less than the TSSR 3.11.D acceptance criteria was a violation of 10CFR50 Appendix B Criterion XVI.

A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because licensee personnel failed to identify that, during a surveillance test, the "B" emergency service water (ESW) pump was inoperable after the flow for the "B" train of ESW was below the required value in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the licensee had erroneously concluded that the pump was operable based on a non-safety system cooled by the "B" train of ESW being tagged out of service. This finding is greater than minor and could become a more significant safety concern because operators failed to recognize inoperable equipment during surveillance testing. The ESW system provides cooling water to the emergency diesel generators (EDGs) and the room coolers for the emergency core cooling system (ECCS) pumps. The failure of ESW is applicable to the mitigating systems cornerstone, because the failure of the ESW system could affect the safety function of the EDGs and/or the ECCS pumps. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the low flow condition for the "B" ESW pump was not of significant magnitude to preclude the system from meeting its safety function. (Section 40A2.b(2)(a))

Inspection Report# : [2002006\(pdf\)](#)

Significance:  Aug 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate operability evaluation for suspect agastat timers resulted in failure to promptly identify failed timer for the "D" RHR pump and a violation of 10CFR50 Appendix B Criterion XVI.

A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because FitzPatrick personnel failed to adequately evaluate the operability of the emergency diesel generator (EDG) Agastat sequence timers controlling the residual heat removal (RHR) pumps. The RHR timers were of the same type and surveillance frequency as the core spray (CS) timers which had failed their Technical Specification required surveillance test. When the RHR timers were tested, the "D" RHR pump timer failed to meet the value listed in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the FitzPatrick basis for operability failed to recognize that the surveillance frequency for the RHR timers had been extended from 6 months to 24 months, a contributing factor for the CS timers failing. This finding is greater than minor and could have become a more significant safety concern because personnel failed to perform adequate operability determinations for suspect conditions adverse to quality. The Agastat timers are used to sequence emergency equipment and system loads onto the EDGs at pre-determined intervals, in order to minimize the potential for damage to the EDGs. The failure of an RHR Agastat timer for the EDG sequencer timer is applicable to the mitigating systems cornerstone, because the failure of timers could result in multiple loads sequencing onto the EDG at the same time, which could affect the reliability of the EDGs or the loads supplied by the EDGs. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the out-of-tolerance condition for the "D" RHR pump timer was not of significant magnitude to preclude the system from meeting its safety function. (Section 40A2.b(2)(b))

Inspection Report# : [2002006\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Jun 03, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Used resin shipment exceeded free standing liquid limits resulting in a violation of 10 CFR 61.56(b)(2).

The inspector identified a non-cited violation of 10 CFR 61.56(b)(2) having very low safety significance. On June 3, 2002, Entergy failed to assure that a spent resin waste container, received for disposal at the Chem-Nuclear Low Level

Waste Disposal Facility in Barnwell, South Carolina, contained less than the allowable limit for free-standing liquid. Entergy's failure to assure that the spent resin shipped for disposal met the de-watering criteria was determined to have very low safety significance using the Public Radiation Safety Significance Determination Process. The finding involved radioactive material control relative to non-conformance with pertinent waste characteristic specifications required for radioactive waste materials tendered for disposal at a licensed waste disposal facility. In this case, the conformance issue was not significant enough to result in denial of access to the disposal facility; and no other issues involving transportation requirements, such as package integrity, Certificate of Compliance, or radiation limits were involved.

Inspection Report# : [2002005\(pdf\)](#)

Physical Protection

Miscellaneous

Last modified : May 30, 2003

FitzPatrick 2Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

The use of inadequate engineering analyas to extend the surveillance interval for the CS and RHR pump timer relays was a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control."

Entergy failed to follow engineering procedure guidance for an analysis of the CS and RHR pump timer relays that was performed to support extending the surveillance test interval for these relays from six months to two years. The engineering procedure required that because the span of the available instrument drift data was not large enough to cover the proposed new test interval, instrument drift for this analysis must be assumed to be time dependent; however, Entergy's analysis erroneously assumed that the timer relay drift values were time independent. This issue had a credible impact on safety because failure of the relays to operate within the TS time limits could delay the injection of water to the reactor during a LOCA. The inspector determined this issue to be of very low safety significance because it did not result in an actual loss of safety function for the CS and RHR systems.

Inspection Report# : [2002007\(pdf\)](#)

Significance:  Aug 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to identify that the "B" ESW pump was inoperable after results of a TS required ST were less than the TSSR 3.11.D acceptance criteria was a violation of 10CFR50 Appendix B Criterion XVI.

A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because licensee personnel failed to identify that, during a surveillance test, the "B" emergency service water (ESW) pump was inoperable after the flow for the "B" train of ESW was below the required value in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the licensee had erroneously concluded that the pump was operable based on a non-safety system cooled by the "B" train of ESW being tagged out of service. This finding is greater than minor and could become a more significant safety concern because operators failed to recognize inoperable equipment during surveillance testing. The ESW system provides cooling water to the emergency diesel generators (EDGs) and the room coolers for the emergency core cooling system (ECCS) pumps. The failure of ESW is applicable to the mitigating systems cornerstone, because the failure of the ESW system could affect the safety function of the EDGs and/or the ECCS pumps. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the low flow condition for the "B" ESW pump was not of significant magnitude to preclude the system from meeting its safety function. (Section 40A2.b(2)(a))

Inspection Report# : [2002006\(pdf\)](#)



Significance: Aug 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate operability evaluation for suspect agastat timers resulted in failure to promptly identify failed timer for the "D" RHR pump and a violation of 10CFR50 Appendix B Criterion XVI.

A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because FitzPatrick personnel failed to adequately evaluate the operability of the emergency diesel generator (EDG) Agastat sequence timers controlling the residual heat removal (RHR) pumps. The RHR timers were of the same type and surveillance frequency as the core spray (CS) timers which had failed their Technical Specification required surveillance test. When the RHR timers were tested, the "D" RHR pump timer failed to meet the value listed in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the FitzPatrick basis for operability failed to recognize that the surveillance frequency for the RHR timers had been extended from 6 months to 24 months, a contributing factor for the CS timers failing. This finding is greater than minor and could have become a more significant safety concern because personnel failed to perform adequate operability determinations for suspect conditions adverse to quality. The Agastat timers are used to sequence emergency equipment and system loads onto the EDGs at pre-determined intervals, in order to minimize the potential for damage to the EDGs. The failure of an RHR Agastat timer for the EDG sequencer timer is applicable to the mitigating systems cornerstone, because the failure of timers could result in multiple loads sequencing onto the EDG at the same time, which could affect the reliability of the EDGs or the loads supplied by the EDGs. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the out-of-tolerance condition for the "D" RHR pump timer was not of significant magnitude to preclude the system from meeting its safety function. (Section 40A2.b(2)(b))

Inspection Report# : [2002006\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : September 04, 2003

FitzPatrick

3Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective actions associated with the failure of RCIC pump discharge flow controller 13FIC-91.

A self-revealing finding occurred during a reactor core isolation cooling (RCIC) surveillance test on June 10, in which the system's flow controller did not automatically respond to maintain the proper RCIC flow after RCIC flow was manually decreased. This degraded condition resulted from inadequate preventive maintenance on the flow controller. The inspectors identified a violation for ineffective corrective action based on a similar flow controller problem, which had occurred in July 2000, but for which corrective actions did not properly address the extent of the condition, and the RCIC flow degradation recurred.

The finding is more than minor, because it affected the mitigating systems cornerstone attribute of equipment performance. The degraded condition of RCIC could have prevented the system from providing adequate flow to the reactor. Therefore, this deficiency affected the reliability and capability of a system that responds to initiating events to prevent undesirable consequences. In accordance with MC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors determined that this finding is of very low safety significance, because it was not a design or qualification deficiency, and it did not result in an actual loss of safety function for the RCIC system with respect to internal or external events.

Inspection Report# : [2003008\(pdf\)](#)

Significance:  Jul 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate and untimely corrective action for a 1996 RHR pump discharge check valve failure resulted in a similar failure in Oct 2002 and a violation of 10CFR50 Appendix B Criterion XVI.

The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI concerning the failure of the D residual heat removal (RHR) pump discharge check valve during the October 2002 refueling outage. This failure resulted due to inadequate corrective action for a similar December 1996 A RHR pump discharge check valve disk hangar arm failure and involved an inappropriate deferral of actions and planned engineering work which was lost track of.

This finding is more than minor because it impacted the mitigating systems cornerstone objective of ensuring the availability and reliability of mitigating systems. During the refueling outage the failure of the D RHR pump discharge check valve could have prevented the B RHR train from performing its shutdown cooling safety function. At the time of the finding the plant was in the refuel mode, with both RHR shutdown cooling systems out of service for

maintenance and the decay heat removal system in service. In accordance with NRC Manual 609, Appendix G, "Shutdown Operation Significance Determination Process," the finding is considered to be of very low safety significance because the shutdown cooling safety function was not significantly degraded.
Inspection Report# : [2003005\(pdf\)](#)

Barrier Integrity

Significance:  Mar 20, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate corrective action for 1997 part 21 caused D inboard MSIV to fail to close during fast-closure surveillance testing on 3/20/2003 and resulted in a violation of 10CFR50 App. B, Criterion XVI.

A self-revealing non-cited violation of 10CFR50 Appendix B, Criterion XVI, was identified when inadequate corrective action for a May 2, 1997 10CFR21 notification, regarding Automative Valve Company (AVC) solenoid valve degradation, caused the D inboard main steam isolation valve (MSIV) to fail to close during fast-closure surveillance testing on March 20, 2003. As corrective action for this violation Entergy revised its preventative maintenance procedures for installed pilot solenoid valves to ensure identification of valve degradation before future failures occur.

This finding is more than minor because it affected the Barrier Integrity Cornerstone objective of providing reasonable assurance of the functionality of containment. The failure of MSIVs to close during an event could provide a release path for radio nuclides from the reactor coolant system to the environment. The finding is of very low safety significance because all of the remaining seven MSIVs closed during the fast closure surveillance testing, and thus the finding did not represent an actual open pathway in the physical integrity of the reactor containment.

Inspection Report# : [2003005\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : December 01, 2003

FitzPatrick 4Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Sep 25, 2003

Identified By: Self Disclosing

Item Type: FIN Finding

Inadequate corrective action resulted in RWR pump trip and unplanned power reduction.

The inspectors identified a self-revealing finding involving inadequate corrective action for a 1999 reactor water recirculation (RWR) pump trip that resulted in another RWR pump trip and unplanned power reduction on September 25, 2003.

The finding is considered more than minor because it is associated with the equipment performance attribute and resulted in an unplanned plant transient that affected the reactor safety initiating events cornerstone objective of limiting the likelihood of events that upset plant stability. The finding is of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2003010\(pdf\)](#)

Mitigating Systems

Significance:  Oct 02, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Calculation Assumption for Station Blackout Battery Load Shed not Translated into the Procedure

The team identified a non-cited violation (NCV) regarding the licensee's failure to incorporate the assumptions of the battery loading calculations into the station's operating procedures for a station blackout, as required by 10CFR50, Appendix B, Criterion III, Design Control.

This finding is more than minor since it is associated with the design control attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Oct 02, 2003

Identified By: NRC

Item Type: FIN Finding

Preconditioning of HPCI Valves Prior to Stroke Time Testing

The team identified that the High Pressure Coolant Injection (HPCI) surveillance procedures failed to test four valves in the as-found condition because the valves were operated at least one time prior to performing the ASME in-service timing test.

This finding is more than minor since it is associated with the procedure quality attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Oct 02, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Replacement of Switches for EDG Output Breaker Cubicles

The team identified a NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, involving the licensee's failure to replace the 52STA switches in three of the four emergency diesel generator (EDG) output breaker cubicles in a timely manner.

This finding is more than minor since it is associated with the equipment performance attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective actions associated with the failure of RCIC pump discharge flow controller 13FIC-91.

During a reactor core isolation cooling (RCIC) surveillance test on June 10 the system's flow controller did not immediately return system flow rate to its setpoint value after flow decreased when operators manually raised system pressure. The degraded condition was caused by inadequate preventive maintenance that resulted from ineffective corrective action for a similar flow controller problem that occurred in July 2000.

The finding is more than minor, because it affected the mitigating systems cornerstone attribute of equipment performance. The degraded condition of RCIC could have prevented the system from providing adequate flow to the reactor. Therefore, this deficiency affected the reliability and capability of a system that responds to initiating events to prevent undesirable consequences. In accordance with MC 0609, Appendix A, "Significance Determination of Reactor

Inspection Findings for At-Power Situations," the inspectors determined that this finding is of very low safety significance, because it was not a design or qualification deficiency, and it did not result in an actual loss of safety function for the RCIC system with respect to internal or external events.

Inspection Report# : [2003008\(pdf\)](#)

Significance:  Jul 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate and untimely corrective action for a 1996 RHR pump discharge check valve failure resulted in a similar failure in Oct 2002 and a violation of 10CFR50 Appendix B Criterion XVI.

The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI concerning the failure of the D residual heat removal (RHR) pump discharge check valve during the October 2002 refueling outage. This failure resulted due to inadequate corrective action for a similar December 1996 A RHR pump discharge check valve disk hangar arm failure and involved an inappropriate deferral of actions and planned engineering work which was lost track of.

This finding is more than minor because it impacted the mitigating systems cornerstone objective of ensuring the availability and reliability of mitigating systems. During the refueling outage the failure of the D RHR pump discharge check valve could have prevented the B RHR train from performing its shutdown cooling safety function. At the time of the finding the plant was in the refuel mode, with both RHR shutdown cooling systems out of service for maintenance and the decay heat removal system in service. In accordance with NRC Manual 609, Appendix G, "Shutdown Operation Significance Determination Process," the finding is considered to be of very low safety significance because the shutdown cooling safety function was not significantly degraded.

Inspection Report# : [2003005\(pdf\)](#)

Barrier Integrity

Significance:  Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate procedure for isolation of control room ventilation during a LOCA.

The inspectors identified a non-cited violation of 10CFR 50, Appendix B, Criterion III, "Design Control," that requires regulatory requirements and the design basis to be correctly translated into procedures. Entergy revised an abnormal operating procedure such that isolation of the control room envelope following a loss of coolant accident (LOCA) would not be initiated as analyzed in the design basis control room habitability calculation described in the UFSAR.

The finding is more than minor because it is associated with the procedure quality and adequacy attribute and affected the objective of the reactor safety barrier integrity cornerstone to provide reasonable assurance that physical design barriers protect control room operators from radiological releases caused by accidents. The finding was of very low safety significance because it represented only a degradation of the radiological barrier function provided for the control room, and the increased operator dose would not have exceeded regulatory limits.

Inspection Report# : [2003010\(pdf\)](#)



Significance: Mar 20, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate corrective action for 1997 part 21 caused D inboard MSIV to fail to close during fast-closure surveillance testing on 3/20/2003 and resulted in a violation of 10CFR50 App. B, Criterion XVI.

A self-revealing non-cited violation of 10CFR 50, Appendix B, Criterion XVI was identified when the D inboard main steam isolation valve (MSIV) failed to close during fast-closure surveillance testing on March 20, 2003. This malfunction occurred because of ineffective corrective action for a May 2, 1997, 10 CFR 21 notification that addressed Automatic Valve Company (AVC) solenoid valve failures.

This finding is more than minor because it affected the barrier integrity cornerstone objective of providing reasonable assurance of the functionality of containment. The failure of the MSIVs to close during an event could provide a release path for radio nuclides from the reactor coolant system to the environment. The finding is of very low safety significance because all of the remaining seven MSIVs closed during the fast closure surveillance testing, and thus the finding did not represent an actual open pathway in the physical integrity of the reactor containment.

Inspection Report# : [2003005\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : March 02, 2004

FitzPatrick 1Q/2004 Plant Inspection Findings

Initiating Events



Significance: Sep 25, 2003

Identified By: Self Disclosing

Item Type: FIN Finding

Inadequate corrective action resulted in RWR pump trip and unplanned power reduction.

The inspectors identified a self-revealing finding involving inadequate corrective action for a 1999 reactor water recirculation (RWR) pump trip that resulted in another RWR pump trip and unplanned power reduction on September 25, 2003.

The finding is considered more than minor because it is associated with the equipment performance attribute and resulted in an unplanned plant transient that affected the reactor safety initiating events cornerstone objective of limiting the likelihood of events that upset plant stability. The finding is of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2003010\(pdf\)](#)

Mitigating Systems



Significance: Oct 02, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Calculation Assumption for Station Blackout Battery Load Shed not Translated into the Procedure

The team identified a non-cited violation (NCV) regarding the licensee's failure to incorporate the assumptions of the battery loading calculations into the station's operating procedures for a station blackout, as required by 10CFR50, Appendix B, Criterion III, Design Control.

This finding is more than minor since it is associated with the design control attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)



Significance: Oct 02, 2003

Identified By: NRC

Item Type: FIN Finding

Preconditioning of HPCI Valves Prior to Stroke Time Testing

The team identified that the High Pressure Coolant Injection (HPCI) surveillance procedures failed to test four valves in the as-found condition because the valves were operated at least one time prior to performing the ASME in-service timing test.

This finding is more than minor since it is associated with the procedure quality attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

G**Significance:** Oct 02, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Replacement of Switches for EDG Output Breaker Cubicles

The team identified a NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, involving the licensee's failure to replace the 52STA switches in three of the four emergency diesel generator (EDG) output breaker cubicles in a timely manner.

This finding is more than minor since it is associated with the equipment performance attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)G**Significance:** Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective actions associated with the failure of RCIC pump discharge flow controller 13FIC-91.

During a reactor core isolation cooling (RCIC) surveillance test on June 10 the system's flow controller did not immediately return system flow rate to its setpoint value after flow decreased when operators manually raised system pressure. The degraded condition was caused by inadequate preventive maintenance that resulted from ineffective corrective action for a similar flow controller problem that occurred in July 2000.

The finding is more than minor, because it affected the mitigating systems cornerstone attribute of equipment performance. The degraded condition of RCIC could have prevented the system from providing adequate flow to the reactor. Therefore, this deficiency affected the reliability and capability of a system that responds to initiating events to prevent undesirable consequences. In accordance with MC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors determined that this finding is of very low safety significance, because it was not a design or qualification deficiency, and it did not result in an actual loss of safety function for the RCIC system with respect to internal or external events.

Inspection Report# : [2003008\(pdf\)](#)G**Significance:** Jul 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate and untimely corrective action for a 1996 RHR pump discharge check valve failure resulted in a similar failure in Oct 2002 and a violation of 10CFR50 Appendix B Criterion XVI.

The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI concerning the failure of the D residual heat removal (RHR) pump discharge check valve during the October 2002 refueling outage. This failure resulted due to inadequate corrective action for a similar December 1996 A RHR pump discharge check valve disk hangar arm failure and involved an inappropriate deferral of actions and planned engineering work which was lost track of.

This finding is more than minor because it impacted the mitigating systems cornerstone objective of ensuring the availability and reliability of mitigating systems. During the refueling outage the failure of the D RHR pump discharge check valve could have prevented the B RHR train from performing its shutdown cooling safety function. At the time of the finding the plant was in the refuel mode, with both RHR shutdown cooling systems out of service for maintenance and the decay heat removal system in service. In accordance with NRC Manual 609, Appendix G, "Shutdown Operation Significance Determination Process," the finding is considered to be of very low safety significance because the shutdown cooling safety function was not significantly degraded.

Inspection Report# : [2003005\(pdf\)](#)

Barrier Integrity

G**Significance:** Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate procedure for isolation of control room ventilation during a LOCA.

The inspectors identified a non-cited violation of 10CFR 50, Appendix B, Criterion III, "Design Control," that requires regulatory requirements and the design basis to be correctly translated into procedures. Entergy revised an abnormal operating procedure such that isolation of the control room envelope following a loss of coolant accident (LOCA) would not be initiated as analyzed in the design basis control room habitability calculation described in the UFSAR.

The finding is more than minor because it is associated with the procedure quality and adequacy attribute and affected the objective of the reactor safety barrier integrity cornerstone to provide reasonable assurance that physical design barriers protect control room operators from radiological releases caused by accidents. The finding was of very low safety significance because it represented only a degradation of the radiological barrier function provided for the control room, and the increased operator dose would not have exceeded regulatory limits.

Inspection Report# : [2003010\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : May 05, 2004

FitzPatrick 2Q/2004 Plant Inspection Findings

Initiating Events

Significance:  Sep 25, 2003
Identified By: Self Disclosing
Item Type: FIN Finding

Inadequate corrective action resulted in RWR pump trip and unplanned power reduction.

The inspectors identified a self-revealing finding involving inadequate corrective action for a 1999 reactor water recirculation (RWR) pump trip that resulted in another RWR pump trip and unplanned power reduction on September 25, 2003.

The finding is considered more than minor because it is associated with the equipment performance attribute and resulted in an unplanned plant transient that affected the reactor safety initiating events cornerstone objective of limiting the likelihood of events that upset plant stability. The finding is of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2003010\(pdf\)](#)

Mitigating Systems

Significance:  Jun 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation

Violation of 10 CFR 55.49 for potential exam compromise during administration of annual operating exam.

The inspectors identified an NCV of 10 CFR 55.49 when they observed each operator of a crew using the same copy of an approved procedure to complete a job performance measure (JPM) during the annual operating test. The inspectors determined that the test was potentially compromised because an operator using this copy of the procedure could have identified the procedure steps necessary to successfully complete the JPM based on placekeeping marks made by previously tested operators.

The violation was more than minor because it adversely affected the mitigating systems cornerstone attribute of human performance. A licensed operator without the requisite skills and knowledge could have passed the annual requalification operating test, and this could have affected the ability of operators to respond to an initiating event and prevent undesirable consequences. Based on IMC 0609, Appendix I, "Operator Requalification Human Performance SDP," the finding was of very low safety significance because Entergy took immediate corrective actions and there was no evidence of actual exam compromise.

Inspection Report# : [2004003\(pdf\)](#)

Significance:  Oct 02, 2003
Identified By: NRC
Item Type: NCV NonCited Violation

Calculation Assumption for Station Blackout Battery Load Shed not Translated into the Procedure

The team identified a non-cited violation (NCV) regarding the licensee's failure to incorporate the assumptions of the battery loading calculations into the station's operating procedures for a station blackout, as required by 10CFR50, Appendix B, Criterion III, Design Control.

This finding is more than minor since it is associated with the design control attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Oct 02, 2003
Identified By: NRC

Item Type: FIN Finding

Preconditioning of HPCI Valves Prior to Stroke Time Testing

The team identified that the High Pressure Coolant Injection (HPCI) surveillance procedures failed to test four valves in the as-found condition because the valves were operated at least one time prior to performing the ASME in-service timing test.

This finding is more than minor since it is associated with the procedure quality attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Oct 02, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Replacement of Switches for EDG Output Breaker Cubicles

The team identified a NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, involving the licensee's failure to replace the 52STA switches in three of the four emergency diesel generator (EDG) output breaker cubicles in a timely manner.

This finding is more than minor since it is associated with the equipment performance attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Jul 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate and untimely corrective action for a 1996 RHR pump discharge check valve failure resulted in a similar failure in Oct 2002 and a violation of 10CFR50 Appendix B Criterion XVI.

The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI concerning the failure of the D residual heat removal (RHR) pump discharge check valve during the October 2002 refueling outage. This failure resulted due to inadequate corrective action for a similar December 1996 A RHR pump discharge check valve disk hangar arm failure and involved an inappropriate deferral of actions and planned engineering work which was lost track of.

This finding is more than minor because it impacted the mitigating systems cornerstone objective of ensuring the availability and reliability of mitigating systems. During the refueling outage the failure of the D RHR pump discharge check valve could have prevented the B RHR train from performing its shutdown cooling safety function. At the time of the finding the plant was in the refuel mode, with both RHR shutdown cooling systems out of service for maintenance and the decay heat removal system in service. In accordance with NRC Manual 609, Appendix G, "Shutdown Operation Significance Determination Process," the finding is considered to be of very low safety significance because the shutdown cooling safety function was not significantly degraded.

Inspection Report# : [2003005\(pdf\)](#)

Barrier Integrity

Significance:  Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate procedure for isolation of control room ventilation during a LOCA.

The inspectors identified a non-cited violation of 10CFR 50, Appendix B, Criterion III, "Design Control," that requires regulatory requirements and the design basis to be correctly translated into procedures. Entergy revised an abnormal operating procedure such that isolation of the control room envelope following a loss of coolant accident (LOCA) would not be initiated as analyzed in the design basis control room habitability calculation described in the UFSAR.

The finding is more than minor because it is associated with the procedure quality and adequacy attribute and affected the objective of the reactor safety barrier integrity cornerstone to provide reasonable assurance that physical design barriers protect control room operators from radiological releases caused by accidents. The finding was of very low safety significance because it represented only a degradation of the radiological barrier function provided for the control room, and the increased operator dose would not have exceeded regulatory limits.

Inspection Report# : [2003010\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : September 08, 2004

FitzPatrick 3Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Transient Combustible Control Requirements for the Screenwell Not Met

The inspectors identified that transient combustible control requirements for resin storage in the screenwell house were not met. The weight and location of the resin exceeded administrative limits and a transient combustible evaluation (TCE) was not performed. The finding was of very low safety significance (Green) and resulted in a noncited violation of Technical Specification (TS) 5.4.1.d that requires fire protection program procedures be implemented.

The performance deficiency involved failure to comply with procedure requirements concerning storage of transient combustible material and ensuring that an engineering assessment was completed when specified. Traditional enforcement does not apply because the issue did not have any actual safety consequences or potential for impacting the NRC's regulatory function and it was not the result of any willful violation of NRC requirements. The finding was more than minor because the quantity of combustible material incorrectly stored exceeded the limits of the screenwell smoke and hot gas analysis (See example 4.k in NRC Inspection Manual 0612, Appendix E). It was associated with the protection against external factors attribute of the mitigating systems cornerstone and negatively affected the objective of maintaining the reliability of the mitigating systems located in the screenwell house, the ESW and RHR service water pumps. The finding had a human performance cross-cutting aspect because it involved personnel not following procedure instructions.

Inspection Report# : [2004004\(pdf\)](#)

Significance:  Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Violation of 10 CFR 55.49 for potential exam compromise during administration of annual operating exam.

The inspectors identified an NCV of 10 CFR 55.49 when they observed each operator of a crew using the same copy of an approved procedure to complete a job performance measure (JPM) during the annual operating test. The inspectors determined that the test was potentially compromised because an operator using this copy of the procedure could have identified the procedure steps necessary to successfully complete the JPM based on placekeeping marks made by previously tested operators.

The violation was more than minor because it adversely affected the mitigating systems cornerstone attribute of human performance. A licensed operator without the requisite skills and knowledge could have passed the annual requalification operating test, and this could have affected the ability of operators to respond to an initiating event and prevent undesirable consequences. Based on IMC 0609, Appendix I, "Operator Requalification Human Performance SDP," the finding was of very low safety significance because Entergy took immediate corrective actions and there was no evidence of actual exam compromise.

Inspection Report# : [2004003\(pdf\)](#)

Significance:  Oct 02, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Calculation Assumption for Station Blackout Battery Load Shed not Translated into the Procedure

The team identified a non-cited violation (NCV) regarding the licensee's failure to incorporate the assumptions of the battery loading calculations into the station's operating procedures for a station blackout, as required by 10CFR50, Appendix B, Criterion III, Design Control.

This finding is more than minor since it is associated with the design control attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

G

Significance: Oct 02, 2003

Identified By: NRC

Item Type: FIN Finding

Preconditioning of HPCI Valves Prior to Stroke Time Testing

The team identified that the High Pressure Coolant Injection (HPCI) surveillance procedures failed to test four valves in the as-found condition because the valves were operated at least one time prior to performing the ASME in-service timing test.

This finding is more than minor since it is associated with the procedure quality attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

G

Significance: Oct 02, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Replacement of Switches for EDG Output Breaker Cubicles

The team identified a NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, involving the licensee's failure to replace the 52STA switches in three of the four emergency diesel generator (EDG) output breaker cubicles in a timely manner.

This finding is more than minor since it is associated with the equipment performance attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The issue was not a design or qualification deficiency that the licensee had evaluated in accordance with GL 91-18, and was determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for internal or external event initiated core damage sequences.

Inspection Report# : [2003009\(pdf\)](#)

Barrier Integrity

G

Significance: Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate procedure for isolation of control room ventilation during a LOCA.

The inspectors identified a non-cited violation of 10CFR 50, Appendix B, Criterion III, "Design Control," that requires regulatory requirements and the design basis to be correctly translated into procedures. Entergy revised an abnormal operating procedure such that isolation of the control room envelope following a loss of coolant accident (LOCA) would not be initiated as analyzed in the design basis control room habitability calculation described in the UFSAR.

The finding is more than minor because it is associated with the procedure quality and adequacy attribute and affected the objective of the reactor safety barrier integrity cornerstone to provide reasonable assurance that physical design barriers protect control room operators from radiological releases caused by accidents. The finding was of very low safety significance because it represented only a degradation of the radiological barrier function provided for the control room, and the increased operator dose would not have exceeded regulatory limits.

Inspection Report# : [2003010\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : December 29, 2004

FitzPatrick 4Q/2004 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to comply with TS 3.8.1 required actions for one offsite circuit inoperable

An NRC-identified non-cited violation of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," was identified for failure to comply with the LCO required actions for one offsite power circuit inoperable within the specified time requirements.

This issue is more than minor because it is associated with the initiating events cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding was determined to be of very low risk significance (Green) because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

Inspection Report# : [2004005\(pdf\)](#)**G****Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate procedure for RPV leak testing resulted in inadvertent reactor vessel level decrease

A self-revealing violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for failure to provide a procedure appropriate to the circumstances. Specifically, surveillance procedure ST-39H, "RPV System Leakage Test and CRD Class-2 Piping Inservice Test," did not include adequate precautions for reactor vessel level control. This resulted in operators draining 120 inches from the reactor vessel with the only on-scale level indicator out of service for testing.

This finding is more than minor because it is associated with the procedure quality and configuration control attributes of the initiating events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions while shutdown. In accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," dated May 25, 2004, the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation. The finding is associated with the cross cutting area of human performance because in addition to the inadequate procedure, it involved operators' failure to maintain adequate control of equipment status during operations in accordance with Entergy administrative procedure (AP)-19.01, "Conduct of Operations."

Inspection Report# : [2004005\(pdf\)](#)

Mitigating Systems

G**Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for 23MOV-14 seat leakage

An NRC-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failure to correct a condition adverse to quality involving high pressure coolant injection (HPCI) turbine steam supply isolation valve 23MOV-14 seat leakage. In November 2004 this resulted in 53 hours of unplanned HPCI system unavailability due to emergent corrective maintenance to address degradation of the valve disc and seat.

This issue is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability of systems that respond to initiating events. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation.

Inspection Report# : [2004005\(pdf\)](#)

Significance: **G** Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Transient Combustible Control Requirements for the Screenwell Not Met

The inspectors identified that transient combustible control requirements for resin storage in the screenwell house were not met. The weight and location of the resin exceeded administrative limits and a transient combustible evaluation (TCE) was not performed. The finding was of very low safety significance (Green) and resulted in a noncited violation of Technical Specification (TS) 5.4.1.d that requires fire protection program procedures be implemented.

The performance deficiency involved failure to comply with procedure requirements concerning storage of transient combustible material and ensuring that an engineering assessment was completed when specified.

The finding was more than minor because the quantity of combustible material incorrectly stored exceeded the limits of the screenwell smoke and hot gas analysis (See example 4.k in NRC Inspection Manual 0612, Appendix E). It was associated with the protection against external factors attribute of the mitigating systems cornerstone and negatively affected the objective of maintaining the reliability of the mitigating systems located in the scenewell house, the ESW and RHR service water pumps.

The finding had a human performance cross-cutting aspect because it involved personnel not following procedure instructions.

Inspection Report# : [2004004\(pdf\)](#)

Significance: **G** Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Violation of 10 CFR 55.49 for potential exam compromise during administration of annual operating exam

The inspectors identified an NCV of 10 CFR 55.49 when they observed each operator of a crew using the same copy of an approved procedure to complete a job performance measure (JPM) during the annual operating test. The inspectors determined that the test was potentially compromised because an operator using this copy of the procedure could have identified the procedure steps necessary to successfully complete the JPM based on placekeeping marks made by previously tested operators.

The violation was more than minor because it adversely affected the mitigating systems cornerstone attribute of human performance. A licensed operator without the requisite skills and knowledge could have passed the annual requalification operating test, and this could have affected the ability of operators to respond to an initiating event and prevent undesirable consequences. Based on IMC 0609, Appendix I, "Operator Requalification Human Performance SDP," the finding was of very low safety significance because Entergy took immediate corrective actions and there was no evidence of actual exam compromise.

Inspection Report# : [2004003\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : March 09, 2005

FitzPatrick

1Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to comply with TS 3.8.1 required actions for one offsite circuit inoperable

An NRC-identified non-cited violation of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," was identified for failure to comply with the LCO required actions for one offsite power circuit inoperable within the specified time requirements.

This issue is more than minor because it is associated with the initiating events cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding was determined to be of very low risk significance (Green) because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

Inspection Report# : [2004005\(pdf\)](#)**G****Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate procedure for RPV leak testing resulted in inadvertent reactor vessel level decrease

A self-revealing violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for failure to provide a procedure appropriate to the circumstances. Specifically, surveillance procedure ST-39H, "RPV System Leakage Test and CRD Class-2 Piping Inservice Test," did not include adequate precautions for reactor vessel level control. This resulted in operators draining 120 inches from the reactor vessel with the only on-scale level indicator out of service for testing.

This finding is more than minor because it is associated with the procedure quality and configuration control attributes of the initiating events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions while shutdown. In accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," dated May 25, 2004, the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation. The finding is associated with the cross cutting area of human performance because in addition to the inadequate procedure, it involved operators' failure to maintain adequate control of equipment status during operations in accordance with Entergy administrative procedure (AP)-19.01, "Conduct of Operations."

Inspection Report# : [2004005\(pdf\)](#)

Mitigating Systems

G**Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for 23MOV-14 seat leakage

An NRC-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failure to correct a condition adverse to quality involving high pressure coolant injection (HPCI) turbine steam supply isolation valve 23MOV-14 seat leakage. In November 2004 this resulted in 53 hours of unplanned HPCI system unavailability due to emergent corrective maintenance to address degradation of the valve disc and seat.

This issue is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability of systems that respond to initiating events. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation.

Inspection Report# : [2004005\(pdf\)](#)

Significance: **G** Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Transient Combustible Control Requirements for the Screenwell Not Met

The inspectors identified that transient combustible control requirements for resin storage in the screenwell house were not met. The weight and location of the resin exceeded administrative limits and a transient combustible evaluation (TCE) was not performed. The finding was of very low safety significance (Green) and resulted in a noncited violation of Technical Specification (TS) 5.4.1.d that requires fire protection program procedures be implemented.

The performance deficiency involved failure to comply with procedure requirements concerning storage of transient combustible material and ensuring that an engineering assessment was completed when specified.

The finding was more than minor because the quantity of combustible material incorrectly stored exceeded the limits of the screenwell smoke and hot gas analysis (See example 4.k in NRC Inspection Manual 0612, Appendix E). It was associated with the protection against external factors attribute of the mitigating systems cornerstone and negatively affected the objective of maintaining the reliability of the mitigating systems located in the scenewell house, the ESW and RHR service water pumps.

The finding had a human performance cross-cutting aspect because it involved personnel not following procedure instructions.

Inspection Report# : [2004004\(pdf\)](#)

Significance: **G** Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Violation of 10 CFR 55.49 for potential exam compromise during administration of annual operating exam

The inspectors identified an NCV of 10 CFR 55.49 when they observed each operator of a crew using the same copy of an approved procedure to complete a job performance measure (JPM) during the annual operating test. The inspectors determined that the test was potentially compromised because an operator using this copy of the procedure could have identified the procedure steps necessary to successfully complete the JPM based on placekeeping marks made by previously tested operators.

The violation was more than minor because it adversely affected the mitigating systems cornerstone attribute of human performance. A licensed operator without the requisite skills and knowledge could have passed the annual requalification operating test, and this could have affected the ability of operators to respond to an initiating event and prevent undesirable consequences. Based on IMC 0609, Appendix I, "Operator Requalification Human Performance SDP," the finding was of very low safety significance because Entergy took immediate corrective actions and there was no evidence of actual exam compromise.

Inspection Report# : [2004003\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : June 17, 2005

FitzPatrick 2Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to comply with TS 3.8.1 required actions for one offsite circuit inoperable

An NRC-identified non-cited violation of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," was identified for failure to comply with the LCO required actions for one offsite power circuit inoperable within the specified time requirements.

This issue is more than minor because it is associated with the initiating events cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding was determined to be of very low risk significance (Green) because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

Inspection Report# : [2004005\(pdf\)](#)

Significance: G Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate procedure for RPV leak testing resulted in inadvertent reactor vessel level decrease

A self-revealing violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for failure to provide a procedure appropriate to the circumstances. Specifically, surveillance procedure ST-39H, "RPV System Leakage Test and CRD Class-2 Piping Inservice Test," did not include adequate precautions for reactor vessel level control. This resulted in operators draining 120 inches from the reactor vessel with the only on-scale level indicator out of service for testing.

This finding is more than minor because it is associated with the procedure quality and configuration control attributes of the initiating events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions while shutdown. In accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," dated May 25, 2004, the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation. The finding is associated with the cross cutting area of human performance because in addition to the inadequate procedure, it involved operators' failure to maintain adequate control of equipment status during operations in accordance with Entergy administrative procedure (AP)-19.01, "Conduct of Operations."

Inspection Report# : [2004005\(pdf\)](#)

Mitigating Systems

Significance: G Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for 23MOV-14 seat leakage

An NRC-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failure to correct a condition adverse to quality involving high pressure coolant injection (HPCI) turbine steam supply isolation valve 23MOV-14 seat leakage. In November 2004 this resulted in 53 hours of unplanned HPCI system unavailability due to emergent corrective maintenance to address degradation of the valve disc and seat.

This issue is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability of systems that respond to initiating events. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation.

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Transient Combustible Control Requirements for the Screenwell Not Met

The inspectors identified that transient combustible control requirements for resin storage in the screenwell house were not met. The weight and location of the resin exceeded administrative limits and a transient combustible evaluation (TCE) was not performed. The finding was of very low safety significance (Green) and resulted in a noncited violation of Technical Specification (TS) 5.4.1.d that requires fire protection program procedures be implemented.

The performance deficiency involved failure to comply with procedure requirements concerning storage of transient combustible material and ensuring that an engineering assessment was completed when specified.

The finding was more than minor because the quantity of combustible material incorrectly stored exceeded the limits of the screenwell smoke and hot gas analysis (See example 4.k in NRC Inspection Manual 0612, Appendix E). It was associated with the protection against external factors attribute of the mitigating systems cornerstone and negatively affected the objective of maintaining the reliability of the mitigating systems located in the screenwell house, the ESW and RHR service water pumps.

The finding had a human performance cross-cutting aspect because it involved personnel not following procedure instructions.

Inspection Report# : [2004004\(pdf\)](#)

Barrier Integrity

Significance:  Apr 02, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for SGT fan vibrations

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for Entergy's failure to adequately evaluate and correct a condition adverse to quality involving a degrading trend in vibration for the B standby gas treatment (SGT) fan assembly. In March 2005 this resulted in 35 hours of unplanned B SGT unavailability due to emergent corrective maintenance to address increasing vibration levels.

The issue was more than minor because it was associated with the operational capability and operations/maintenance performance attributes of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance of containment integrity to protect the public from radiological releases. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the Phase 1 screening for the containment barriers cornerstone resulted in a finding of very low risk significance (Green) because the finding only represented a degradation of the radiological barrier function provided by the SGT system.

Inspection Report# : [2005003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Aug 05, 2004

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The NRC team determined that Entergy was effective at identifying discrepant conditions at an appropriate threshold and entering them into the corrective action program. Once entered into the system, issues were typically prioritized appropriately and in a timely fashion; and were properly evaluated commensurate with the safety significance. Overall, the evaluations reasonably identified the causes of the problem, the extent of the condition, and provided for corrective actions to address the causes. However, the team noted some minor instances where long-standing and recurring equipment problems were not effectively evaluated and corrected in a timely fashion. On the basis of interviews conducted, the team determined that plant staff personnel were familiar with and utilized the corrective action program to identify problems.

Inspection Report# : [2004006\(pdf\)](#)

Last modified : August 24, 2005

FitzPatrick 3Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate AOP Resulted In Reactor Trip

A self-revealing NCV of Technical Specification (TS) 5.4, "Procedures", occurred when Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, abnormal operating procedure (AOP)-21, "Loss of UPS," did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of uninterruptible power supply. This resulted in an automatic reactor scram on September 14, 2005, due to low reactor vessel water level. Entergy revised the procedure as a corrective action for this violation.

The finding is greater than minor because it affected the procedure adequacy attribute of the initiating event cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and is not potentially risk significant due to external events. This finding is associated with the human performance cross-cutting area in that Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, AOP-21 did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of UPS.

Inspection Report# : [2005005\(pdf\)](#)**G****Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to comply with TS 3.8.1 required actions for one offsite circuit inoperable

An NRC-identified non-cited violation of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," was identified for failure to comply with the LCO required actions for one offsite power circuit inoperable within the specified time requirements.

This issue is more than minor because it is associated with the initiating events cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding was determined to be of very low risk significance (Green) because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

Inspection Report# : [2004005\(pdf\)](#)**G****Significance:** Dec 31, 2004

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate procedure for RPV leak testing resulted in inadvertent reactor vessel level decrease

A self-revealing violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for failure to provide a procedure appropriate to the circumstances. Specifically, surveillance procedure ST-39H, "RPV System Leakage Test and CRD Class-2 Piping Inservice Test," did not include adequate precautions for reactor vessel level control. This resulted in operators draining 120 inches from the reactor vessel with the only on-scale level indicator out of service for testing.

This finding is more than minor because it is associated with the procedure quality and configuration control attributes of the initiating events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions while shutdown. In accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," dated May 25, 2004, the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation. The finding is associated with the cross cutting area of human performance because in addition to the inadequate procedure, it involved operators' failure to maintain adequate control of equipment status during operations in accordance with Entergy administrative procedure (AP)-19.01, "Conduct of Operations."

Inspection Report# : [2004005\(pdf\)](#)

Mitigating Systems

Significance:  Jul 01, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Control of West Cable Tunnel Cooler 67E-11

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," because Entergy did not maintain adequate design control of the west cable tunnel unit cooler (UC) 67E-11 to ensure that it would perform its safety-related function under design basis conditions. Specifically, Entergy did not adequately evaluate the ability of the cooler to remove its design basis heat load with 22 tubes plugged and the maximum allowable ultimate heat sink temperature of 85 degrees Fahrenheit (F).

The finding is greater than minor because it is associated with the mitigating system cornerstone attributes for design control and equipment performance. It affects the mitigating system cornerstone objective to ensure the availability, reliability and capability of systems and components that are required to power safety-related loads for safe shutdown and accident mitigation. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it is a design deficiency confirmed not to result in a loss of function per NRC Generic Letter 91-18. This finding is documented in Entergy's corrective action program as CR-2005-02467.

Inspection Report# : [2005004\(pdf\)](#)

Significance:  Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for 23MOV-14 seat leakage

An NRC-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failure to correct a condition adverse to quality involving high pressure coolant injection (HPCI) turbine steam supply isolation valve 23MOV-14 seat leakage. In November 2004 this resulted in 53 hours of unplanned HPCI system unavailability due to emergent corrective maintenance to address degradation of the valve disc and seat.

This issue is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability of systems that respond to initiating events. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation.

Inspection Report# : [2004005\(pdf\)](#)

Barrier Integrity

Significance:  Apr 02, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for SGT fan vibrations

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for Entergy's failure to adequately evaluate and correct a condition adverse to quality involving a degrading trend in vibration for the B standby gas treatment (SGT) fan assembly. In March 2005 this resulted in 35 hours of unplanned B SGT unavailability due to emergent corrective maintenance to address increasing vibration levels.

The issue was more than minor because it was associated with the operational capability and operations/maintenance performance attributes of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance of containment integrity to protect the public

from radiological releases. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the Phase 1 screening for the containment barriers cornerstone resulted in a finding of very low risk significance (Green) because the finding only represented a degradation of the radiological barrier function provided by the SGT system.

Inspection Report# : [2005003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : November 30, 2005

FitzPatrick 4Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Comply with TS 3.8.1 Required Actions for One Offsite Power Circuit Inoperable

A Green self-revealing non-cited violation (NCV) of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," occurred for Entergy's failure to comply with the LCO required actions for one inoperable offsite power circuit. The performance deficiency is that the condition of Line 4 was not effectively monitored such that the degraded phase A bus bar was not identified. This resulted in exceeding the TS 3.8.1 allowed outage time. This issue was entered into the corrective action program. The bus bar was repaired and a process to monitor bus voltage was implemented. Long term corrective actions are under development.

The finding is greater than minor significance because it is associated with the Initiating Events Cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding is determined to be of very low risk significance because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)**G****Significance:** Oct 27, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Inspect Safety-Related Pip Support

A Green self-revealing non-cited violation (NCV) was identified for failure to comply with 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." As a result of not adequately implementing a pipe support inspection procedure, a through-wall crack and leakage developed in the common residual heat removal (RHR) shutdown cooling (SDC) system suction pipe. After the leak was found, Entergy identified a 1/32 - inch gap between the pipe and adjacent pipe support PFSK-2084. Because of the gap, PFSK-2084 was not bearing its design load or adequately resisting normal pipe movement during system operation. This resulted in low stress, high cycle fatigue cracking of the pipe.

While the leakage was self-revealing, a performance deficiency existed in that a gap between pipe support PFSK-2084 and the SDC pipe was not identified during an examination in 1985 or in the interval leading up to the fatigue failure in 2005. The finding was more than minor because it affected the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. The leakage resulting from the crack would not have resulted in the loss of the residual heat removal (RHR) system or adversely impacted other mitigating systems. Since the finding did not require a quantitative assessment, it was determined to be Green (very low safety significance) based on Figure 1 of IMC 0609, Appendix G.

Inspection Report# : [2005009\(pdf\)](#)**G****Significance:** Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate AOP Resulted In Reactor Trip

A self-revealing NCV of Technical Specification (TS) 5.4, "Procedures", occurred when Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, abnormal operating procedure (AOP)-21, "Loss of UPS," did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of uninterruptible power supply. This resulted in an automatic reactor scram on September 14, 2005, due to low reactor vessel water level. Entergy revised the procedure as a corrective action for this violation.

The finding is greater than minor because it affected the procedure adequacy attribute of the initiating event cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and is not potentially risk significant due to external events. This finding is associated with the human performance cross-cutting area in that Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, AOP-21 did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of UPS.

Inspection Report# : [2005005\(pdf\)](#)

Mitigating Systems

G**Significance:** Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate 10 CFR 50.59 Safety Evaluation Associated with Safety Relief Valves

A Green (Severity Level IV) non-cited violation of 10 CFR 50.59 was identified for failure to perform an adequate safety evaluation (SE) of a change to the facility. Specifically, Entergy's SE did not adequately evaluate the potential for a malfunction with a different result associated with the elimination of safety relief valve (SRV) accumulator check valve leakage testing. The issue was entered into the corrective action program. An operability evaluation concluded that the equipment was operable and additional corrective actions are under review.

Entergy's less than adequate 10 CFR 50.59 safety evaluation constitutes a performance deficiency. This finding has been addressed using traditional enforcement since it potentially impacted or impeded the regulatory process in that a required 10 CFR 50.59 evaluation was not adequate. This is contrary to the regulatory process that allows licensees to make changes without a license amendment provided that licensees comply with the 10 CFR 50.59 process. The finding is greater than minor, because there was a reasonable likelihood that the change would have required NRC review and approval prior to implementation. This finding was evaluated using the SDP for the mitigating systems cornerstone and was determined to be a finding of very low safety significance (Green), because it did not impact operability of the SRVs, and was not potentially risk-significant due to possible external events. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)**G****Significance:** Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Diesel-Driven Fire Pump Performance

A Green NRC-identified non-cited violation of 10 CFR 50.65(a)(2) was identified for a failure to demonstrate that the performance of the back-up diesel-driven fire pump 76P-4 was being effectively controlled through the performance of appropriate preventive maintenance.

Specifically, the pump did not complete its surveillance runs on at least four occasions between October 2003 and December 2005 due to fouling of the diesel engine cooling water strainer. To address this, maintenance was performed in each case to clean the strainer. However, this maintenance did not prevent recurrence and did not ensure the pump remained capable of performing its intended function. The issue was entered into the corrective action program and corrective actions are under review. The finding is associated with the cross cutting area of problem identification and resolution since there were repetitive failures of the back-up diesel driven fire pump.

The finding is more than minor, because the performance of the component was degraded, and that the degraded performance affected the objectives of the Mitigating Systems Cornerstone. Specifically, the continued reliability of the pump was affected. The inspectors evaluated this finding using the site-specific Phase 2 SDP worksheets. This analysis showed the safety significance to be very low based on alternate sources remaining available. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)**G****Significance:** Oct 27, 2005

Identified By: NRC

Item Type: FIN Finding

Failure To Consider the Relevant Factors in Conducting the Initial Engineering Evaluation of the Flaw in the Torus Shell

A Green self-revealing finding was identified for failure to consider the relevant factors in conducting the initial engineering evaluation of the flaw in the torus shell. Specifically, the initial evaluation of the cracked torus and through-wall leakage did not consider the proximity of the HPCI steam exhaust to the degraded area of the torus shell. The issue was documented in the licensee's corrective action program as CR -JAF-2005-02735, "HPCI Line not Considered in Initial Evaluation of Torus Operability".

This self-revealing finding was of more than minor safety significance because the location of the high pressure coolant injection (HPCI) exhaust line resulted in unanalyzed hydrodynamic loads that resulted in torus cracks and minor leakage. Although this condition placed the torus outside of its design limits, subsequent structural and material analyses of the condition demonstrated that the torus would have been able to perform its mitigating safety function for all design basis transients and accidents. The finding was determined to be Green (very low safety significance) based on IMC 0609, Appendix A, Phase 1 SDP worksheet for at-power situations. The inspectors determined that the finding represented a design deficiency that did not result in a loss of function per Generic Letter 91-18, Revision 1.

Inspection Report# : [2005009\(pdf\)](#)**G****Significance:** Jul 01, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Control of West Cable Tunnel Cooler 67E-11

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," because Entergy did not maintain adequate design control of the west cable tunnel unit cooler (UC) 67E-11 to ensure that it would perform its safety-related function under design basis conditions. Specifically, Entergy did not adequately evaluate the ability of the cooler to remove its design basis heat load with 22 tubes plugged and the maximum allowable ultimate heat sink temperature of 85 degrees Fahrenheit (F).

The finding is greater than minor because it is associated with the mitigating system cornerstone attributes for design control and equipment performance. It affects the mitigating system cornerstone objective to ensure the availability, reliability and capability of systems and components that are required to power safety-related loads for safe shutdown and accident mitigation. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it is a design deficiency confirmed not to result in a loss of function per NRC Generic Letter 91-18. This finding is documented in Entergy's corrective action program as CR-2005-02467.

Inspection Report# : [2005004\(pdf\)](#)

Barrier Integrity

G

Significance: Apr 02, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for SGT fan vibrations

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for Entergy's failure to adequately evaluate and correct a condition adverse to quality involving a degrading trend in vibration for the B standby gas treatment (SGT) fan assembly. In March 2005 this resulted in 35 hours of unplanned B SGT unavailability due to emergent corrective maintenance to address increasing vibration levels.

The issue was more than minor because it was associated with the operational capability and operations/maintenance performance attributes of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance of containment integrity to protect the public from radiological releases. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the Phase 1 screening for the containment barriers cornerstone resulted in a finding of very low risk significance (Green) because the finding only represented a degradation of the radiological barrier function provided by the SGT system.

Inspection Report# : [2005003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : March 03, 2006

FitzPatrick

1Q/2006 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Comply with TS 3.8.1 Required Actions for One Offsite Power Circuit Inoperable

A Green self-revealing non-cited violation (NCV) of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," occurred for Entergy's failure to comply with the LCO required actions for one inoperable offsite power circuit. The performance deficiency is that the condition of Line 4 was not effectively monitored such that the degraded phase A bus bar was not identified. This resulted in exceeding the TS 3.8.1 allowed outage time. This issue was entered into the corrective action program. The bus bar was repaired and a process to monitor bus voltage was implemented. Long term corrective actions are under development.

The finding is greater than minor significance because it is associated with the Initiating Events Cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding is determined to be of very low risk significance because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)**G****Significance:** Oct 27, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Inspect Safety-Related Pipe Support

A Green self-revealing non-cited violation (NCV) was identified for failure to comply with 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." As a result of not adequately implementing a pipe support inspection procedure, a through-wall crack and leakage developed in the common residual heat removal (RHR) shutdown cooling (SDC) system suction pipe. After the leak was found, Entergy identified a 1/32 - inch gap between the pipe and adjacent pipe support PFSK-2084. Because of the gap, PFSK-2084 was not bearing its design load or adequately resisting normal pipe movement during system operation. This resulted in low stress, high cycle fatigue cracking of the pipe.

While the leakage was self-revealing, a performance deficiency existed in that a gap between pipe support PFSK-2084 and the SDC pipe was not identified during an examination in 1985 or in the interval leading up to the fatigue failure in 2005. The finding was more than minor because it affected the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. The leakage resulting from the crack would not have resulted in the loss of the residual heat removal (RHR) system or adversely impacted other mitigating systems. Since the finding did not require a quantitative assessment, it was determined to be Green (very low safety significance) based on Figure 1 of IMC 0609, Appendix G.

Inspection Report# : [2005009\(pdf\)](#)**G****Significance:** Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate AOP Resulted In Reactor Trip

A self-revealing NCV of Technical Specification (TS) 5.4, "Procedures", occurred when Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, abnormal operating procedure (AOP)-21, "Loss of UPS," did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of uninterruptible power supply. This resulted in an automatic reactor scram on September 14, 2005, due to low reactor vessel water level. Entergy revised the procedure as a corrective action for this violation.

The finding is greater than minor because it affected the procedure adequacy attribute of the initiating event cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and is not potentially risk significant due to external events. This finding is associated with the human performance cross-cutting area in that Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, AOP-21 did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of UPS.

Inspection Report# : [2005005\(pdf\)](#)

Mitigating Systems

G**Significance:** Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate 10 CFR 50.59 Safety Evaluation Associated with Safety Relief Valves

A Green (Severity Level IV) non-cited violation of 10 CFR 50.59 was identified for failure to perform an adequate safety evaluation (SE) of a change to the facility. Specifically, Entergy's SE did not adequately evaluate the potential for a malfunction with a different result associated with the elimination of safety relief valve (SRV) accumulator check valve leakage testing. The issue was entered into the corrective action program. An operability evaluation concluded that the equipment was operable and additional corrective actions are under review.

Entergy's less than adequate 10 CFR 50.59 safety evaluation constitutes a performance deficiency. This finding has been addressed using traditional enforcement since it potentially impacted or impeded the regulatory process in that a required 10 CFR 50.59 evaluation was not adequate. This is contrary to the regulatory process that allows licensees to make changes without a license amendment provided that licensees comply with the 10 CFR 50.59 process. The finding is greater than minor, because there was a reasonable likelihood that the change would have required NRC review and approval prior to implementation. This finding was evaluated using the SDP for the mitigating systems cornerstone and was determined to be a finding of very low safety significance (Green), because it did not impact operability of the SRVs, and was not potentially risk-significant due to possible external events. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)**G****Significance:** Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Diesel-Driven Fire Pump Performance

A Green NRC-identified non-cited violation of 10 CFR 50.65(a)(2) was identified for a failure to demonstrate that the performance of the back-up diesel-driven fire pump 76P-4 was being effectively controlled through the performance of appropriate preventive maintenance.

Specifically, the pump did not complete its surveillance runs on at least four occasions between October 2003 and December 2005 due to fouling of the diesel engine cooling water strainer. To address this, maintenance was performed in each case to clean the strainer. However, this maintenance did not prevent recurrence and did not ensure the pump remained capable of performing its intended function. The issue was entered into the corrective action program and corrective actions are under review. The finding is associated with the cross cutting area of problem identification and resolution since there were repetitive failures of the back-up diesel driven fire pump.

The finding is more than minor, because the performance of the component was degraded, and that the degraded performance affected the objectives of the Mitigating Systems Cornerstone. Specifically, the continued reliability of the pump was affected. The inspectors evaluated this finding using the site-specific Phase 2 SDP worksheets. This analysis showed the safety significance to be very low based on alternate sources remaining available. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)**G****Significance:** Oct 27, 2005

Identified By: NRC

Item Type: FIN Finding

Failure To Consider the Relevant Factors in Conducting the Initial Engineering Evaluation of the Flaw in the Torus Shell

A Green self-revealing finding was identified for failure to consider the relevant factors in conducting the initial engineering evaluation of the flaw in the torus shell. Specifically, the initial evaluation of the cracked torus and through-wall leakage did not consider the proximity of the HPCI steam exhaust to the degraded area of the torus shell. The issue was documented in the licensee's corrective action program as CR -JAF-2005-02735, "HPCI Line not Considered in Initial Evaluation of Torus Operability".

This self-revealing finding was of more than minor safety significance because the location of the high pressure coolant injection (HPCI) exhaust line resulted in unanalyzed hydrodynamic loads that resulted in torus cracks and minor leakage. Although this condition placed the torus outside of its design limits, subsequent structural and material analyses of the condition demonstrated that the torus would have been able to perform its mitigating safety function for all design basis transients and accidents. The finding was determined to be Green (very low safety significance) based on IMC 0609, Appendix A, Phase 1 SDP worksheet for at-power situations. The inspectors determined that the finding represented a design deficiency that did not result in a loss of function per Generic Letter 91-18, Revision 1.

Inspection Report# : [2005009\(pdf\)](#)**G****Significance:** Jul 01, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Control of West Cable Tunnel Cooler 67E-11

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," because Entergy did not maintain adequate design control of the west cable tunnel unit cooler (UC) 67E-11 to ensure that it would perform its safety-related function under design basis conditions. Specifically, Entergy did not adequately evaluate the ability of the cooler to remove its design basis heat load with 22 tubes plugged and the maximum allowable ultimate heat sink temperature of 85 degrees Fahrenheit (F).

The finding is greater than minor because it is associated with the mitigating system cornerstone attributes for design control and equipment performance. It affects the mitigating system cornerstone objective to ensure the availability, reliability and capability of systems and components that are required to power safety-related loads for safe shutdown and accident mitigation. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it is a design deficiency confirmed not to result in a loss of function per NRC Generic Letter 91-18. This finding is documented in Entergy's corrective action program as CR-2005-02467.

Inspection Report# : [2005004\(pdf\)](#)

Barrier Integrity

G

Significance: Apr 02, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for SGT fan vibrations

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for Entergy's failure to adequately evaluate and correct a condition adverse to quality involving a degrading trend in vibration for the B standby gas treatment (SGT) fan assembly. In March 2005 this resulted in 35 hours of unplanned B SGT unavailability due to emergent corrective maintenance to address increasing vibration levels.

The issue was more than minor because it was associated with the operational capability and operations/maintenance performance attributes of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance of containment integrity to protect the public from radiological releases. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the Phase 1 screening for the containment barriers cornerstone resulted in a finding of very low risk significance (Green) because the finding only represented a degradation of the radiological barrier function provided by the SGT system.

Inspection Report# : [2005003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : May 25, 2006

FitzPatrick 2Q/2006 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Comply with TS 3.8.1 Required Actions for One Offsite Power Circuit Inoperable

A Green self-revealing non-cited violation (NCV) of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," occurred for Entergy's failure to comply with the LCO required actions for one inoperable offsite power circuit. The performance deficiency is that the condition of Line 4 was not effectively monitored such that the degraded phase A bus bar was not identified. This resulted in exceeding the TS 3.8.1 allowed outage time. This issue was entered into the corrective action program. The bus bar was repaired and a process to monitor bus voltage was implemented. Long term corrective actions are under development.

The finding is greater than minor significance because it is associated with the Initiating Events Cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding is determined to be of very low risk significance because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)**G****Significance:** Oct 27, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Inspect Safety-Related Pipe Support

A Green self-revealing non-cited violation (NCV) was identified for failure to comply with 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." As a result of not adequately implementing a pipe support inspection procedure, a through-wall crack and leakage developed in the common residual heat removal (RHR) shutdown cooling (SDC) system suction pipe. After the leak was found, Entergy identified a 1/32 - inch gap between the pipe and adjacent pipe support PFSK-2084. Because of the gap, PFSK-2084 was not bearing its design load or adequately resisting normal pipe movement during system operation. This resulted in low stress, high cycle fatigue cracking of the pipe.

While the leakage was self-revealing, a performance deficiency existed in that a gap between pipe support PFSK-2084 and the SDC pipe was not identified during an examination in 1985 or in the interval leading up to the fatigue failure in 2005. The finding was more than minor because it affected the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. The leakage resulting from the crack would not have resulted in the loss of the residual heat removal (RHR) system or adversely impacted other mitigating systems. Since the finding did not require a quantitative assessment, it was determined to be Green (very low safety significance) based on Figure 1 of IMC 0609, Appendix G.

Inspection Report# : [2005009\(pdf\)](#)**G****Significance:** Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate AOP Resulted In Reactor Trip

A self-revealing NCV of Technical Specification (TS) 5.4, "Procedures", occurred when Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, abnormal operating procedure (AOP)-21, "Loss of UPS," did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of uninterruptible power supply. This resulted in an automatic reactor scram on September 14, 2005, due to low reactor vessel water level. Entergy revised the procedure as a corrective action for this violation.

The finding is greater than minor because it affected the procedure adequacy attribute of the initiating event cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and is not potentially risk significant due to external events. This finding is associated with the human performance cross-cutting area in that Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, AOP-21 did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of UPS.

Inspection Report# : [2005005\(pdf\)](#)

Mitigating Systems

Significance:  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate 10 CFR 50.59 Safety Evaluation Associated with Safety Relief Valves

A Green (Severity Level IV) non-cited violation of 10 CFR 50.59 was identified for failure to perform an adequate safety evaluation (SE) of a change to the facility. Specifically, Entergy's SE did not adequately evaluate the potential for a malfunction with a different result associated with the elimination of safety relief valve (SRV) accumulator check valve leakage testing. The issue was entered into the corrective action program. An operability evaluation concluded that the equipment was operable and additional corrective actions are under review.

Entergy's less than adequate 10 CFR 50.59 safety evaluation constitutes a performance deficiency. This finding has been addressed using traditional enforcement since it potentially impacted or impeded the regulatory process in that a required 10 CFR 50.59 evaluation was not adequate. This is contrary to the regulatory process that allows licensees to make changes without a license amendment provided that licensees comply with the 10 CFR 50.59 process. The finding is greater than minor, because there was a reasonable likelihood that the change would have required NRC review and approval prior to implementation. This finding was evaluated using the SDP for the mitigating systems cornerstone and was determined to be a finding of very low safety significance (Green), because it did not impact operability of the SRVs, and was not potentially risk-significant due to possible external events. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)

Significance:  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Diesel-Driven Fire Pump Performance

A Green NRC-identified non-cited violation of 10 CFR 50.65(a)(2) was identified for a failure to demonstrate that the performance of the back-up diesel-driven fire pump 76P-4 was being effectively controlled through the performance of appropriate preventive maintenance. Specifically, the pump did not complete its surveillance runs on at least four occasions between October 2003 and December 2005 due to fouling of the diesel engine cooling water strainer. To address this, maintenance was performed in each case to clean the strainer. However, this maintenance did not prevent recurrence and did not ensure the pump remained capable of performing its intended function. The issue was entered into the corrective action program and corrective actions are under review. The finding is associated with the cross cutting area of problem identification and resolution since there were repetitive failures of the back-up diesel driven fire pump.

The finding is more than minor, because the performance of the component was degraded, and that the degraded performance affected the objectives of the Mitigating Systems Cornerstone. Specifically, the continued reliability of the pump was affected. The inspectors evaluated this finding using the site-specific Phase 2 SDP worksheets. This analysis showed the safety significance to be very low based on alternate sources remaining available. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)

Significance:  Oct 27, 2005

Identified By: NRC

Item Type: FIN Finding

Failure To Consider the Relevant Factors in Conducting the Initial Engineering Evaluation of the Flaw in the Torus Shell

A Green self-revealing finding was identified for failure to consider the relevant factors in conducting the initial engineering evaluation of the flaw in the torus shell. Specifically, the initial evaluation of the cracked torus and through-wall leakage did not consider the proximity of the HPCI steam exhaust to the degraded area of the torus shell. The issue was documented in the licensee's corrective action program as CR -JAF-2005-02735, "HPCI Line not Considered in Initial Evaluation of Torus Operability".

This self-revealing finding was of more than minor safety significance because the location of the high pressure coolant injection (HPCI) exhaust line resulted in unanalyzed hydrodynamic loads that resulted in torus cracks and minor leakage. Although this condition placed the torus outside of its design limits, subsequent structural and material analyses of the condition demonstrated that the torus would have been able to perform its mitigating safety function for all design basis transients and accidents. The finding was determined to be Green (very low safety significance) based on IMC 0609, Appendix A, Phase 1 SDP worksheet for at-power situations. The inspectors determined that the finding represented a design deficiency that did not result in a loss of function per Generic Letter 91-18, Revision 1.

Inspection Report# : [2005009\(pdf\)](#)

Significance:  Jul 01, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Control of West Cable Tunnel Cooler 67E-11

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," because Entergy did not maintain adequate design control of the west cable tunnel unit cooler (UC) 67E-11 to ensure that it would perform its safety-related function under design basis conditions. Specifically, Entergy did not adequately evaluate the ability of the cooler to remove its design basis heat load with 22 tubes

plugged and the maximum allowable ultimate heat sink temperature of 85 degrees Fahrenheit (F).

The finding is greater than minor because it is associated with the mitigating system cornerstone attributes for design control and equipment performance. It affects the mitigating system cornerstone objective to ensure the availability, reliability and capability of systems and components that are required to power safety-related loads for safe shutdown and accident mitigation. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it is a design deficiency confirmed not to result in a loss of function per NRC Generic Letter 91-18. This finding is documented in Entergy's corrective action program as CR-2005-02467.

Inspection Report# : [2005004\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : August 25, 2006

FitzPatrick

3Q/2006 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Comply with TS 3.8.1 Required Actions for One Offsite Power Circuit Inoperable

A Green self-revealing non-cited violation (NCV) of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," occurred for Entergy's failure to comply with the LCO required actions for one inoperable offsite power circuit. The performance deficiency is that the condition of Line 4 was not effectively monitored such that the degraded phase A bus bar was not identified. This resulted in exceeding the TS 3.8.1 allowed outage time. This issue was entered into the corrective action program. The bus bar was repaired and a process to monitor bus voltage was implemented. Long term corrective actions are under development.

The finding is greater than minor significance because it is associated with the Initiating Events Cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding is determined to be of very low risk significance because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)

Significance:  Oct 27, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Inspect Safety-Related Pipe Support

A Green self-revealing non-cited violation (NCV) was identified for failure to comply with 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." As a result of not adequately implementing a pipe support inspection procedure, a through-wall crack and leakage developed in the common residual heat removal (RHR) shutdown cooling (SDC) system suction pipe. After the leak was found, Entergy identified a 1/32 - inch gap between the pipe and adjacent pipe support PFSK-2084. Because of the gap, PFSK-2084 was not bearing its design load or adequately resisting normal pipe movement during system operation. This resulted in low stress, high cycle fatigue cracking of the pipe. While the leakage was self-revealing, a performance deficiency existed in that a gap between pipe support PFSK-2084 and the SDC pipe was not identified during an examination in 1985 or in the interval leading up to the fatigue failure in 2005. The finding was more than minor because it affected the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. The leakage resulting from the crack would not have resulted in the loss of the residual heat removal (RHR) system or adversely impacted other mitigating systems. Since the finding did not require a quantitative assessment, it was determined to be Green (very low safety significance) based on Figure 1 of IMC 0609, Appendix G.

Inspection Report# : [2005009\(pdf\)](#)

Mitigating Systems

Significance: SL-IV Jul 01, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Required Medical Report

The inspectors identified a Severity Level IV non-cited violation of 10 CFR 50.74(c), in that, on multiple occasions, Entergy had not reported that licensed operators were taking prescription medications to control potentially disqualifying medical conditions. Once brought to the licensee's attention, this issue was promptly added to their corrective action program. The corrective actions included an extent of condition review by Entergy's medical department and subsequent submission of the required reports to the NRC.

The inspectors determined that Entergy's failure to report potentially disqualifying medical conditions in accordance with 10 CFR 50.74(c) is a performance deficiency. The inspectors also determined that this issue was within Entergy's ability to foresee and prevent. In addition, the inspectors determined that traditional enforcement applies because failure to report to the NRC potentially disqualifying medical conditions of operators impacts the NRC's regulatory function. The inspectors determined that the finding was Severity Level IV using the NRC's Enforcement Policy and Inspection Manual Chapter 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)." Specifically, it involved the failure to report the use of medication to control potentially disqualifying medical conditions in greater than 20 percent of the records reviewed.

Inspection Report# : [2006003\(pdf\)](#)

Significance:  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate 10 CFR 50.59 Safety Evaluation Associated with Safety Relief Valves

A Green (Severity Level IV) non-cited violation of 10 CFR 50.59 was identified for failure to perform an adequate safety evaluation (SE) of a change to the facility. Specifically, Entergy's SE did not adequately evaluate the potential for a malfunction with a different result associated with the elimination of safety relief valve (SRV) accumulator check valve leakage testing. The issue was entered into the corrective action program. An operability evaluation concluded that the equipment was operable and additional corrective actions are under review.

Entergy's less than adequate 10 CFR 50.59 safety evaluation constitutes a performance deficiency. This finding has been addressed using traditional enforcement since it potentially impacted or impeded the regulatory process in that a required 10 CFR 50.59 evaluation was not adequate. This is contrary to the regulatory process that allows licensees to make changes without a license amendment provided that licensees comply with the 10 CFR 50.59 process. The finding is greater than minor, because there was a reasonable likelihood that the change would have required NRC review and approval prior to implementation. This finding was evaluated using the SDP for the mitigating systems cornerstone and was determined to be a finding of very low safety significance (Green), because it did not impact operability of the SRVs, and was not potentially risk-significant due to possible external events. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)

Significance:  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Diesel-Driven Fire Pump Performance

A Green NRC-identified non-cited violation of 10 CFR 50.65(a)(2) was identified for a failure to demonstrate that the performance of the back-up diesel-driven fire pump 76P-4 was being effectively controlled through the performance of appropriate preventive maintenance. Specifically, the pump did not complete its surveillance runs on at least four occasions between October 2003 and December 2005 due to fouling of the diesel engine cooling water strainer. To address this, maintenance was performed in each case to clean the strainer. However, this maintenance did not prevent recurrence and did not ensure the pump remained capable of performing its intended function. The issue was entered into the corrective action program and corrective actions are under review. The finding is associated with the cross cutting area of problem identification and resolution since there were repetitive failures of the back-up diesel driven fire pump.

The finding is more than minor, because the performance of the component was degraded, and that the degraded performance affected the objectives of the Mitigating Systems Cornerstone. Specifically, the continued reliability of the pump was affected. The inspectors evaluated this finding using the site-specific Phase 2 SDP worksheets. This analysis showed the safety significance to be very low based on alternate sources remaining available. Because this finding is of very low safety significance and has been entered in Entergy's corrective action program, the violation is being treated as a non-cited violation.

Inspection Report# : [2005006\(pdf\)](#)

Significance:  Oct 27, 2005

Identified By: NRC

Item Type: FIN Finding

Failure To Consider the Relevant Factors in Conducting the Initial Engineering Evaluation of the Flaw in the Torus Shell

A Green self-revealing finding was identified for failure to consider the relevant factors in conducting the initial engineering evaluation of the flaw in the torus shell. Specifically, the initial evaluation of the cracked torus and through-wall leakage did not consider the proximity of the HPCI steam exhaust to the degraded area of the torus shell. The issue was documented in the licensee's corrective action program as CR -JAF-2005-02735, "HPCI Line not Considered in Initial Evaluation of Torus Operability".

This self-revealing finding was of more than minor safety significance because the location of the high pressure coolant injection (HPCI) exhaust line resulted in unanalyzed hydrodynamic loads that resulted in torus cracks and minor leakage. Although this condition placed the torus outside of its design limits, subsequent structural and material analyses of the condition demonstrated that the torus would have been able to perform its mitigating safety function for all design basis transients and accidents. The finding was determined to be Green (very low safety significance) based on IMC 0609, Appendix A, Phase 1 SDP worksheet for at-power situations. The inspectors determined that the finding represented a design deficiency that did not result in a loss of function per Generic Letter 91-18, Revision 1.

Inspection Report# : [2005009\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Significance:  Jul 28, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Demonstrate that 'B' Train Stack High Range Effluent Radiation Monitor Sample Pump Performance was Effectively Controlled per 10 CFR 50.65(a)(2)

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50.65(a)(2), for Entergy's failure to appropriately classify the January 2006 failure of the 'B' train sample pump, 17P-4B, as a maintenance preventable functional failure. As a result, Entergy did not establish goals or monitor the performance of the stack high range radiation monitor, or demonstrate that monitoring was not required, in accordance with 10 CFR Part 50.65(a)(1).

The inspectors determined that this finding was more than minor because it was similar to Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," Example 7.b, in that, violations of 10 CFR Part 50.65(a)(2) necessarily involve degraded safety system performance or conditions. The finding was determined to be of very low safety significance (Green) because the redundant sample pump remained available and was promptly placed into service when 'B' train sample pump, 17P-4B, failed. The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not use a systematic decision-making process in determining the maintenance rule status of the plant stack high range effluent radiation monitoring system.

Inspection Report# : [2006006\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : December 21, 2006

FitzPatrick

4Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: SL-IV Jul 01, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Required Medical Report

The inspectors identified a Severity Level IV non-cited violation of 10 CFR 50.74(c), in that, on multiple occasions, Entergy had not reported that licensed operators were taking prescription medications to control potentially disqualifying medical conditions. Once brought to the licensee's attention, this issue was promptly added to their corrective action program. The corrective actions included an extent of condition review by Entergy's medical department and subsequent submission of the required reports to the NRC.

The inspectors determined that Entergy's failure to report potentially disqualifying medical conditions in accordance with 10 CFR 50.74(c) is a performance deficiency. The inspectors also determined that this issue was within Entergy's ability to foresee and prevent. In addition, the inspectors determined that traditional enforcement applies because failure to report to the NRC potentially disqualifying medical conditions of operators impacts the NRC's regulatory function. The inspectors determined that the finding was Severity Level IV using the NRC's Enforcement Policy and Inspection Manual Chapter 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)." Specifically, it involved the failure to report the use of medication to control potentially disqualifying medical conditions in greater than 20 percent of the records reviewed.

Inspection Report# : [2006003](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Significance:  Jul 28, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Demonstrate that 'B' Train Stack High Range Effluent Radiation Monitor Sample Pump Performance was Effectively Controlled per 10 CFR 50.65(a)(2)

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50.65(a)(2), for Entergy's failure to appropriately classify the January 2006 failure of the 'B' train sample pump, 17P-4B, as a maintenance preventable functional failure. As a result, Entergy did not establish goals or monitor the performance of the stack high range radiation monitor, or demonstrate that monitoring was not required, in accordance with 10 CFR Part 50.65(a)(1).

The inspectors determined that this finding was more than minor because it was similar to Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," Example 7.b, in that, violations of 10 CFR Part 50.65(a)(2) necessarily involve degraded safety system performance or conditions. The finding was determined to be of very low safety significance (Green) because the redundant sample pump remained available and was promptly placed into service when 'B' train sample pump, 17P-4B, failed. The inspectors determined that this finding had a cross-cutting aspect in the area of

human performance because Entergy did not use a systematic decision-making process in determining the maintenance rule status of the plant stack high range effluent radiation monitoring system.

Inspection Report# : [2006006](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Jul 28, 2006

Identified By: NRC

Item Type: FIN Finding

IDENTIFICATION & RESOLUTION OF PROBLEMS

The team identified that Entergy was effective at identifying problems and putting them into the corrective action program. Entergy's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations that had not been previously identified by Entergy. Entergy effectively used risk in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementing corrective actions. Entergy was effective in evaluating identified deficiencies and developing appropriate corrective actions. Corrective actions were implemented in a timely manner and were effective in correcting identified deficiencies. Entergy audits and self assessments were found to be effective. The team also determined that Entergy effectively used operating experience. In addition, the team determined that workers at the site felt free to enter problems in the corrective action program.

Inspection Report# : [2006006](#) (*pdf*)

Last modified : March 01, 2007

FitzPatrick

1Q/2007 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Risk Assessment When Required by 10 CFR Parat 50.65(a)(4)

A Green, self-revealing, NCV of 10 CFR Part 50.65(a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants" was identified when Entergy did not perform a risk assessment for planned maintenance activities when a tagout was applied on the 'B' electro-hydraulic control (EHC) pump, in conjunction with a previous emergent failure of torus exhaust outer isolation valve 27AOV-118. Entergy performed a risk assessment and entered the deficiency into their corrective action program.

The inspectors determined that this finding affected the initiating events cornerstone; and it was more than minor because it was similar to Example 7(f) in Inspection Manual Chapter 0612, Appendix E, "Examples of Minor Issues," in that, the emergent failure of 27AOV-118, in combination with the subsequent removal of the 'B' electro hydraulic control pump availability resulted in the plant being in a higher risk category, which required risk management actions, under Entergy's on-line risk management procedure. The inspectors evaluated this finding using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP," Flowchart 1, "Assessment of Risk Deficit," and determined the finding to be of very low safety significance (Green) because the finding resulted in an increase in the incremental core damage probability deficit of less than 1×10^{-6} (actual increase was in the high 10^{-8} range).

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not incorporate appropriate risk insights into planned work activities.

Inspection Report# : [2007002](#) (*pdf*)

Mitigating Systems

Significance: SL-IV Jul 01, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Required Medical Report

The inspectors identified a Severity Level IV non-cited violation of 10 CFR 50.74(c), in that, on multiple occasions, Entergy had not reported that licensed operators were taking prescription medications to control potentially disqualifying medical conditions. Once brought to the licensee's attention, this issue was promptly added to their corrective action program. The corrective actions included an extent of condition review by Entergy's medical department and subsequent submission of the required reports to the NRC.

The inspectors determined that Entergy's failure to report potentially disqualifying medical conditions in accordance with 10 CFR 50.74(c) is a performance deficiency. The inspectors also determined that this issue was within Entergy's ability to foresee and prevent. In addition, the inspectors determined that traditional enforcement applies because failure to report to the NRC potentially disqualifying medical conditions of operators impacts the NRC's regulatory function. The inspectors determined that the finding was Severity Level IV using the NRC's Enforcement Policy and Inspection Manual Chapter 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)." Specifically, it involved the failure to report the use of medication to control potentially disqualifying medical conditions in greater than 20 percent of the records reviewed.

Inspection Report# : [2006003](#) (*pdf*)

Barrier Integrity

G**Significance:** Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Maintenance on Containment Atmosphere Control Valve

A Green, self-revealing, non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified when Entergy failed to properly implement a torus exhaust valve maintenance procedure. As a result, on February 25, 2007, valve 27AOV-118 did not open on demand to vent the torus and maintain drywell to torus differential pressure. Entergy entered this issue into their corrective action program and performed an extent of condition review.

The inspectors determined that this finding more than minor because it was associated with the Barrier Performance attribute of the Barrier Integrity cornerstone; and it impacted the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Failure of the valve to operate remotely from the relay room would have required operators to open the valve locally using the manual operator in accordance with procedure Emergency Procedure 6, "Post-Accident Containment Venting and Gas Control." The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment, or involve an actual reduction in defense-in-depth for the atmospheric pressure control or hydrogen control functions of the reactor containment.

Inspection Report# : [2007002](#) (*pdf*)

Emergency Preparedness

G**Significance:** Jul 28, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Demonstrate that 'B' Train Stack High Range Effluent Radiation Monitor Sample Pump Performance was Effectively Controlled per 10 CFR 50.65(a)(2)

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50.65(a)(2), for Entergy's failure to appropriately classify the January 2006 failure of the 'B' train sample pump, 17P-4B, as a maintenance preventable functional failure. As a result, Entergy did not establish goals or monitor the performance of the stack high range radiation monitor, or demonstrate that monitoring was not required, in accordance with 10 CFR Part 50.65(a)(1).

The inspectors determined that this finding was more than minor because it was similar to Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," Example 7.b, in that, violations of 10 CFR Part 50.65(a)(2) necessarily involve degraded safety system performance or conditions. The finding was determined to be of very low safety significance (Green) because the redundant sample pump remained available and was promptly placed into service when 'B' train sample pump, 17P-4B, failed. The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not use a systematic decision-making process in determining the maintenance rule status of the plant stack high range effluent radiation monitoring system.

Inspection Report# : [2006006](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Jul 28, 2006

Identified By: NRC

Item Type: FIN Finding

IDENTIFICATION & RESOLUTION OF PROBLEMS

The team identified that Entergy was effective at identifying problems and putting them into the corrective action program. Entergy's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations that had not been previously identified by Entergy. Entergy effectively used risk in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementing corrective actions. Entergy was effective in evaluating identified deficiencies and developing appropriate corrective actions. Corrective actions were implemented in a timely manner and were effective in correcting identified deficiencies. Entergy audits and self assessments were found to be effective. The team also determined that Entergy effectively used operating experience. In addition, the team determined that workers at the site felt free to enter problems in the corrective action program.

Inspection Report# : [2006006](#) (*pdf*)

Last modified : June 01, 2007

FitzPatrick

2Q/2007 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Risk Assessment When Required by 10 CFR Para 50.65(a)(4)

A Green, self-revealing, NCV of 10 CFR Part 50.65(a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants" was identified when Entergy did not perform a risk assessment for planned maintenance activities when a tagout was applied on the 'B' electro-hydraulic control (EHC) pump, in conjunction with a previous emergent failure of torus exhaust outer isolation valve 27AOV-118. Entergy performed a risk assessment and entered the deficiency into their corrective action program.

The inspectors determined that this finding affected the initiating events cornerstone; and it was more than minor because it was similar to Example 7(f) in Inspection Manual Chapter 0612, Appendix E, "Examples of Minor Issues," in that, the emergent failure of 27AOV-118, in combination with the subsequent removal of the 'B' electro hydraulic control pump availability resulted in the plant being in a higher risk category, which required risk management actions, under Entergy's on-line risk management procedure. The inspectors evaluated this finding using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP," Flowchart 1, "Assessment of Risk Deficit," and determined the finding to be of very low safety significance (Green) because the finding resulted in an increase in the incremental core damage probability deficit of less than 1×10^{-6} (actual increase was in the high 10-8 range).

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not incorporate appropriate risk insights into planned work activities.

Inspection Report# : [2007002](#) (*pdf*)

Mitigating Systems

Significance: SL-IV Jul 01, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Required Medical Report

The inspectors identified a Severity Level IV non-cited violation of 10 CFR 50.74(c), in that, on multiple occasions, Entergy had not reported that licensed operators were taking prescription medications to control potentially disqualifying medical conditions. Once brought to the licensee's attention, this issue was promptly added to their corrective action program. The corrective actions included an extent of condition review by Entergy's medical department and subsequent submission of the required reports to the NRC.

The inspectors determined that Entergy's failure to report potentially disqualifying medical conditions in accordance with 10 CFR 50.74(c) is a performance deficiency. The inspectors also determined that this issue was within Entergy's ability to foresee and prevent. In addition, the inspectors determined that traditional enforcement applies because failure to report to the NRC potentially disqualifying medical conditions of operators impacts the NRC's regulatory function. The inspectors determined that the finding was Severity Level IV using the NRC's Enforcement Policy and Inspection Manual Chapter 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)." Specifically, it involved the failure to report the use of medication to control potentially disqualifying medical conditions in greater than 20 percent of the records reviewed.

Inspection Report# : [2006003](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Maintenance on Containment Atmosphere Control Valve

A Green, self-revealing, non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified when Entergy failed to properly implement a torus exhaust valve maintenance procedure. As a result, on February 25, 2007, valve 27AOV-118 did not open on demand to vent the torus and maintain drywell to torus differential pressure. Entergy entered this issue into their corrective action program and performed an extent of condition review.

The inspectors determined that this finding more than minor because it was associated with the Barrier Performance attribute of the Barrier Integrity cornerstone; and it impacted the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Failure of the valve to operate remotely from the relay room would have required operators to open the valve locally using the manual operator in accordance with procedure Emergency Procedure 6, "Post-Accident Containment Venting and Gas Control." The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment, or involve an actual reduction in defense-in-depth for the atmospheric pressure control or hydrogen control functions of the reactor containment.

Inspection Report# : [2007002](#) (*pdf*)

Emergency Preparedness

Significance:  Jul 28, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Demonstrate that 'B' Train Stack High Range Effluent Radiation Monitor Sample Pump Performance was Effectively Controlled per 10 CFR 50.65(a)(2)

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50.65(a)(2), for Entergy's failure to appropriately classify the January 2006 failure of the 'B' train sample pump, 17P-4B, as a maintenance preventable functional failure. As a result, Entergy did not establish goals or monitor the performance of the stack high range radiation monitor, or demonstrate that monitoring was not required, in accordance with 10 CFR Part 50.65(a)(1).

The inspectors determined that this finding was more than minor because it was similar to Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," Example 7.b, in that, violations of 10 CFR Part 50.65(a)(2) necessarily involve degraded safety system performance or conditions. The finding was determined to be of very low safety significance (Green) because the redundant sample pump remained available and was promptly placed into service when 'B' train sample pump, 17P-4B, failed. The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not use a systematic decision-making process in determining the maintenance rule status of the plant stack high range effluent radiation monitoring system.

Inspection Report# : [2006006](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Jul 28, 2006

Identified By: NRC

Item Type: FIN Finding

IDENTIFICATION & RESOLUTION OF PROBLEMS

The team identified that Entergy was effective at identifying problems and putting them into the corrective action program. Entergy's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations that had not been previously identified by Entergy. Entergy effectively used risk in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementing corrective actions. Entergy was effective in evaluating identified deficiencies and developing appropriate corrective actions. Corrective actions were implemented in a timely manner and were effective in correcting identified deficiencies. Entergy audits and self assessments were found to be effective. The team also determined that Entergy effectively used operating experience. In addition, the team determined that workers at the site felt free to enter problems in the corrective action program.

Inspection Report# : [2006006](#) (*pdf*)

Last modified : August 24, 2007

FitzPatrick

3Q/2007 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Risk Assessment When Required by 10 CFR Para 50.65(a)(4)

A Green, self-revealing, NCV of 10 CFR Part 50.65(a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants" was identified when Entergy did not perform a risk assessment for planned maintenance activities when a tagout was applied on the 'B' electro-hydraulic control (EHC) pump, in conjunction with a previous emergent failure of torus exhaust outer isolation valve 27AOV-118. Entergy performed a risk assessment and entered the deficiency into their corrective action program.

The inspectors determined that this finding affected the initiating events cornerstone; and it was more than minor because it was similar to Example 7(f) in Inspection Manual Chapter 0612, Appendix E, "Examples of Minor Issues," in that, the emergent failure of 27AOV-118, in combination with the subsequent removal of the 'B' electro hydraulic control pump availability resulted in the plant being in a higher risk category, which required risk management actions, under Entergy's on-line risk management procedure. The inspectors evaluated this finding using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP," Flowchart 1, "Assessment of Risk Deficit," and determined the finding to be of very low safety significance (Green) because the finding resulted in an increase in the incremental core damage probability deficit of less than 1×10^{-6} (actual increase was in the high 10⁻⁸ range).

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not incorporate appropriate risk insights into planned work activities.

Inspection Report# : [2007002](#) (*pdf*)

Mitigating Systems

Significance:  Sep 28, 2007

Identified By: NRC

Item Type: FIN Finding

Failure to correct negative slope of the reactor core isolation cooling system flow instrument sensing lines.

A self-revealing finding was identified involving inadequate corrective actions when Entergy did not correct an adverse condition on the reactor core isolation cooling (RCIC) system flow instrument sensing lines. The condition allowed air bubbles to form in the sensing lines, resulting in an erroneous flow indication. Consequently, the RCIC system would not have been able to achieve its design flow rate of 410 gallons per minute (gpm). Entergy entered the condition into their corrective action program and implemented interim corrective actions by revising the RCIC operating procedure to vent the sensing lines. In addition, Entergy has scheduled activities to correct the instrument sensing line condition.

The inspectors determined that this finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone; and, it impacted the cornerstone objective of ensuring the availability, reliability, and capability of the RCIC system to respond to initiating events to prevent undesirable consequences. Specifically, the RCIC system would not have been able to achieve its design flow rate of 410 gpm. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, ASignificance Determination of Reactor Inspection Findings for At-Power Situations,@ and determined it to be of very low safety significance (Green) because it was not associated with a design or qualification deficiency, it did not represent any actual loss of a system safety function, it did not represent the actual loss of a safety function of a single train for greater than its Technical Specification allowed outage time, and it was not potentially risk significant due to a seismic, flooding, or severe weather initiating event.

Inspection Report# : [2007004 \(pdf\)](#)

Significance:  Jul 20, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to maintain adequate design basis calculations for safety-related motors.

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The team determined that Entergy did not maintain appropriate design basis calculations to ensure that the safety-related motors for the emergency service water (ESW) and standby liquid control (SLC) pumps had adequate starting voltage.

The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of the ESW and SLC systems to respond to initiating events to prevent undesirable consequences. This finding is of very low significance because it did not result in the loss of operability.

This finding has a cross-cutting aspect in the area of human performance (Resources component) because Entergy did not ensure that adequate resources were available to maintain complete, accurate and up-to-date design documentation. (IMC 0305, aspect H.2.(c)) (Section 1R21.2.1.1)

Inspection Report# : [2007006 \(pdf\)](#)

Significance:  Jul 20, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

EDG FOST capacity calculation did not account for vortexing.

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The team determined that Entergy failed to properly identify and evaluate the potential for vortexing in the emergency diesel generator (EDG) fuel oil transfer pump (FOTP) suction inlet piping. Specifically, Entergy's EDG fuel oil storage tank (FOST) inventory calculation did not include any allowance for suction line submergence to prevent air entrainment resulting from the effects of vortexing.

The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of the EDGs to respond to initiating events to prevent undesirable consequences. This finding is of very low significance because it did not result in the loss of safety function.

This finding has a cross-cutting aspect in the area of problem identification and resolution (PI&R) (Self - and Independent Assessments component) because Entergy did not ensure that design basis self assessments were of sufficient depth, comprehensive, appropriately objective, and self-critical. (IMC 0305, aspect P.3.(a)) (Section 1R21.2.1.2)

Inspection Report# : [2007006 \(pdf\)](#)

Barrier Integrity

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Maintenance on Containment Atmosphere Control Valve

A Green, self-revealing, non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified when Entergy failed to properly implement a torus exhaust valve maintenance procedure. As a result, on February 25, 2007, valve 27AOV-118 did not open on demand to vent the torus and maintain drywell to torus differential pressure. Entergy entered this issue into their corrective action program and performed an extent of condition review.

The inspectors determined that this finding more than minor because it was associated with the Barrier Performance

attribute of the Barrier Integrity cornerstone; and it impacted the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Failure of the valve to operate remotely from the relay room would have required operators to open the valve locally using the manual operator in accordance with procedure Emergency Procedure 6, “Post-Accident Containment Venting and Gas Control.” The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, “Significance Determination of Reactor Inspection Findings for At-Power Situations,” and determined it to be of very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment, or involve an actual reduction in defense-in-depth for the atmospheric pressure control or hydrogen control functions of the reactor containment.

Inspection Report# : [2007002](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : December 07, 2007

FitzPatrick

4Q/2007 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Procedure Associated with Lake Condition Monitoring

A self-revealing NCV of Technical Specification 5.4, "Procedures," was identified when operators did not implement certain steps specified in Operations Shift Standing Order 2007-020, "Lake Condition Monitoring," Revision 4, which increased the likelihood of a scram. Entergy entered the condition into their corrective action program, revised the lake condition monitoring procedure, and discussed procedure adherence expectations with operators.

The inspectors determined that this finding is more than minor because it is associated with the Human Performance attribute (human error) of the Initiating Events cornerstone; and it impacted the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety function during shutdown as well as power operations. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At Power Situation," and determined it to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment functions would not be available.

This finding had a cross-cutting aspect in the area of human performance because Entergy did not ensure that expectations regarding procedural compliance were met. (H.4(b)) (Section 4OA3)

Inspection Report# : [2007005](#) (*pdf*)

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: FIN Finding

Feedwater Low Flow Control Valve Degradation Led to Primary Containment Isolation System Group Two Isolation

A self-revealing finding was identified involving inadequate corrective actions when Entergy failed to correct the adverse condition of the feedwater low-flow control valve, 34FCV-137. Entergy also failed to implement corrective actions in a timely manner to remotely monitor feedwater flow rate through the feedwater low-flow control valve in order to support level control. This condition resulted in a low level scram and primary containment isolation system group two isolation on September 12, 2007, and October 28, 2007. This problem was entered into Entergy's corrective action program. Following the October 28, 2007, manual scram and subsequent low level scram, Entergy replaced the stem and packing box for the low-flow control valve and implemented an interim method to remotely monitor feedwater flow rate. In addition, Entergy has scheduled a design change to provide low-range feedwater flow rate instrumentation in the control room.

The inspectors determined that this finding is more than minor because it is associated with the equipment performance attribute of the Initiating Events cornerstone, and it impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated this finding using Phase 1 of Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not take appropriate corrective actions, in a timely manner, to address the feedwater

low-flow control valve degradation and to provide a method to monitor the feedwater control system response following the low level scram and primary containment isolation system group two isolation on September 12, 2007. Consequently, another low level scram and primary containment isolation system group two isolation occurred on October 28, 2007. (P.1(d)) (Section 40A3)

Inspection Report# : [2007005](#) (*pdf*)

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Risk Assessment When Required by 10 CFR Para 50.65(a)(4)

A Green, self-revealing, NCV of 10 CFR Part 50.65(a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants" was identified when Entergy did not perform a risk assessment for planned maintenance activities when a tagout was applied on the 'B' electro-hydraulic control (EHC) pump, in conjunction with a previous emergent failure of torus exhaust outer isolation valve 27AOV-118. Entergy performed a risk assessment and entered the deficiency into their corrective action program.

The inspectors determined that this finding affected the initiating events cornerstone; and it was more than minor because it was similar to Example 7(f) in Inspection Manual Chapter 0612, Appendix E, "Examples of Minor Issues," in that, the emergent failure of 27AOV-118, in combination with the subsequent removal of the 'B' electro hydraulic control pump availability resulted in the plant being in a higher risk category, which required risk management actions, under Entergy's on-line risk management procedure. The inspectors evaluated this finding using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP," Flowchart 1, "Assessment of Risk Deficit," and determined the finding to be of very low safety significance (Green) because the finding resulted in an increase in the incremental core damage probability deficit of less than 1×10^{-6} (actual increase was in the high 10⁻⁸ range).

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not incorporate appropriate risk insights into planned work activities. (H.3(a))

Inspection Report# : [2007002](#) (*pdf*)

Mitigating Systems

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Risk Assessment When Required by 10 CFR Part 50.65(a)(4)

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy failed to perform a risk assessment prior to commencing performance of Instrument Surveillance Procedure ISP-175A1, "Reactor Containment Cooling Instrument Functional Test/ Calibration." This was due to instrument and control technicians performing the procedure which was not in accordance with the plant work schedule. This problem was entered into Entergy's corrective action program. Corrective actions included communicating the error to personnel, conducting human performance training, and improving administrative control of procedures.

The inspectors determined that the finding impacted the Mitigating Systems cornerstone because it impacted the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding is more than minor because the licensee's risk assessment failed to consider risk significant structures, systems, and components (i.e., high pressure coolant injection and reactor core isolation cooling) that were unavailable during the maintenance period.

Using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP," Flowchart 1, "Assessment of Risk Deficit," the inspectors determined the incremental core damage probability deficit from

Entergy's core damage frequency as a result of the actual duration of ISP-175A1 (1.07 hours). The inspectors calculated the incremental core damage probability deficit and determined it to be significantly lower than 1E-6. Because the calculated risk deficit was not greater than 1E-6 incremental core damage probability deficit, the inspectors determined that this finding was of very low safety significance (Green).

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the instrument and control technicians involved did not effectively implement the expected human error prevention techniques (e.g., self-checking, prejob briefs, and proper documentation of activities), to ensure the correct procedure was used in accordance with the work schedule. (H.4(a)) (Section 1R13)

Inspection Report# : [2007005](#) (*pdf*)

Significance:  Sep 28, 2007

Identified By: NRC

Item Type: FIN Finding

Failure to correct negative slope of the reactor core isolation cooling system flow instrument sensing lines.

A self-revealing finding was identified involving inadequate corrective actions when Entergy did not correct an adverse condition on the reactor core isolation cooling (RCIC) system flow instrument sensing lines. The condition allowed air bubbles to form in the sensing lines, resulting in an erroneous flow indication. Consequently, the RCIC system would not have been able to achieve its design flow rate of 410 gallons per minute (gpm). Entergy entered the condition into their corrective action program and implemented interim corrective actions by revising the RCIC operating procedure to vent the sensing lines. In addition, Entergy has scheduled activities to correct the instrument sensing line condition.

The inspectors determined that this finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone; and, it impacted the cornerstone objective of ensuring the availability, reliability, and capability of the RCIC system to respond to initiating events to prevent undesirable consequences. Specifically, the RCIC system would not have been able to achieve its design flow rate of 410 gpm. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, ASignificance Determination of Reactor Inspection Findings for At-Power Situations,@ and determined it to be of very low safety significance (Green) because it was not associated with a design or qualification deficiency, it did not represent any actual loss of a system safety function, it did not represent the actual loss of a safety function of a single train for greater than its Technical Specification allowed outage time, and it was not potentially risk significant due to a seismic, flooding, or severe weather initiating event.

Inspection Report# : [2007004](#) (*pdf*)

Significance:  Jul 20, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to maintain adequate design basis calculations for safety-related motors.

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The team determined that Entergy did not maintain appropriate design basis calculations to ensure that the safety-related motors for the emergency service water (ESW) and standby liquid control (SLC) pumps had adequate starting voltage.

The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of the ESW and SLC systems to respond to initiating events to prevent undesirable consequences. This finding is of very low significance because it did not result in the loss of operability.

This finding has a cross-cutting aspect in the area of human performance (Resources component) because Entergy did not ensure that adequate resources were available to maintain complete, accurate and up-to-date design documentation. (H.2(c))

Inspection Report# : [2007006](#) (*pdf*)

G**Significance:** Jul 20, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

EDG FOST capacity calculation did not account for vortexing.

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The team determined that Entergy failed to properly identify and evaluate the potential for vortexing in the emergency diesel generator (EDG) fuel oil transfer pump (FOTP) suction inlet piping. Specifically, Entergy's EDG fuel oil storage tank (FOST) inventory calculation did not include any allowance for suction line submergence to prevent air entrainment resulting from the effects of vortexing.

The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of the EDGs to respond to initiating events to prevent undesirable consequences. This finding is of very low significance because it did not result in the loss of safety function.

This finding has a cross-cutting aspect in the area of problem identification and resolution (PI&R) (Self - and Independent Assessments component) because Entergy did not ensure that design basis self assessments were of sufficient depth, comprehensive, appropriately objective, and self-critical. (P.3(a))
Inspection Report# : [2007006](#) (*pdf*)

Barrier Integrity

G**Significance:** Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Maintenance on Containment Atmosphere Control Valve

A Green, self-revealing, non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified when Entergy failed to properly implement a torus exhaust valve maintenance procedure. As a result, on February 25, 2007, valve 27AOV-118 did not open on demand to vent the torus and maintain drywell to torus differential pressure. Entergy entered this issue into their corrective action program and performed an extent of condition review.

The inspectors determined that this finding more than minor because it was associated with the Barrier Performance attribute of the Barrier Integrity cornerstone; and it impacted the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Failure of the valve to operate remotely from the relay room would have required operators to open the valve locally using the manual operator in accordance with procedure Emergency Procedure 6, "Post-Accident Containment Venting and Gas Control." The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment, or involve an actual reduction in defense-in-depth for the atmospheric pressure control or hydrogen control functions of the reactor containment.

Inspection Report# : [2007002](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : February 04, 2008

FitzPatrick

1Q/2008 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Procedure Associated with Lake Condition Monitoring

A self-revealing NCV of Technical Specification 5.4, "Procedures," was identified when operators did not implement certain steps specified in Operations Shift Standing Order 2007-020, "Lake Condition Monitoring," Revision 4, which increased the likelihood of a scram. Entergy entered the condition into their corrective action program, revised the lake condition monitoring procedure, and discussed procedure adherence expectations with operators.

The inspectors determined that this finding is more than minor because it is associated with the Human Performance attribute (human error) of the Initiating Events cornerstone; and it impacted the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety function during shutdown as well as power operations. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At Power Situation," and determined it to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment functions would not be available.

This finding had a cross-cutting aspect in the area of human performance because Entergy did not ensure that expectations regarding procedural compliance were met. (H.4(b)) (Section 4OA3)

Inspection Report# : [2007005](#) (*pdf*)

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: FIN Finding

Feedwater Low Flow Control Valve Degradation Led to Primary Containment Isolation System Group Two Isolation

A self-revealing finding was identified involving inadequate corrective actions when Entergy failed to correct the adverse condition of the feedwater low-flow control valve, 34FCV-137. Entergy also failed to implement corrective actions in a timely manner to remotely monitor feedwater flow rate through the feedwater low-flow control valve in order to support level control. This condition resulted in a low level scram and primary containment isolation system group two isolation on September 12, 2007, and October 28, 2007. This problem was entered into Entergy's corrective action program. Following the October 28, 2007, manual scram and subsequent low level scram, Entergy replaced the stem and packing box for the low-flow control valve and implemented an interim method to remotely monitor feedwater flow rate. In addition, Entergy has scheduled a design change to provide low-range feedwater flow rate instrumentation in the control room.

The inspectors determined that this finding is more than minor because it is associated with the equipment performance attribute of the Initiating Events cornerstone, and it impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated this finding using Phase 1 of Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not take appropriate corrective actions, in a timely manner, to address the feedwater low-flow control valve degradation and to provide a method to monitor the feedwater control system response

following the low level scram and primary containment isolation system group two isolation on September 12, 2007. Consequently, another low level scram and primary containment isolation system group two isolation occurred on October 28, 2007. (P.1(d)) (Section 40A3)

Inspection Report# : [2007005 \(pdf\)](#)

Mitigating Systems

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Risk Assessment When Required by 10 CFR Part 50.65(a)(4)

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy failed to perform a risk assessment prior to commencing performance of Instrument Surveillance Procedure ISP-175A1, "Reactor Containment Cooling Instrument Functional Test/ Calibration." This was due to instrument and control technicians performing the procedure which was not in accordance with the plant work schedule. This problem was entered into Entergy's corrective action program. Corrective actions included communicating the error to personnel, conducting human performance training, and improving administrative control of procedures.

The inspectors determined that the finding impacted the Mitigating Systems cornerstone because it impacted the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding is more than minor because the licensee's risk assessment failed to consider risk significant structures, systems, and components (i.e., high pressure coolant injection and reactor core isolation cooling) that were unavailable during the maintenance period.

Using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP," Flowchart 1, "Assessment of Risk Deficit," the inspectors determined the incremental core damage probability deficit from Entergy's core damage frequency as a result of the actual duration of ISP-175A1 (1.07 hours). The inspectors calculated the incremental core damage probability deficit and determined it to be significantly lower than 1E-6. Because the calculated risk deficit was not greater than 1E-6 incremental core damage probability deficit, the inspectors determined that this finding was of very low safety significance (Green).

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the instrument and control technicians involved did not effectively implement the expected human error prevention techniques (e.g., self-checking, prejob briefs, and proper documentation of activities), to ensure the correct procedure was used in accordance with the work schedule. (H.4(a)) (Section 1R13)

Inspection Report# : [2007005 \(pdf\)](#)

Significance:  Sep 28, 2007

Identified By: NRC

Item Type: FIN Finding

Failure to correct negative slope of the reactor core isolation cooling system flow instrument sensing lines.

A self-revealing finding was identified involving inadequate corrective actions when Entergy did not correct an adverse condition on the reactor core isolation cooling (RCIC) system flow instrument sensing lines. The condition allowed air bubbles to form in the sensing lines, resulting in an erroneous flow indication. Consequently, the RCIC system would not have been able to achieve its design flow rate of 410 gallons per minute (gpm). Entergy entered the condition into their corrective action program and implemented interim corrective actions by revising the RCIC operating procedure to vent the sensing lines. In addition, Entergy has scheduled activities to correct the instrument sensing line condition.

The inspectors determined that this finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone; and, it impacted the cornerstone objective of ensuring

the availability, reliability, and capability of the RCIC system to respond to initiating events to prevent undesirable consequences. Specifically, the RCIC system would not have been able to achieve its design flow rate of 410 gpm. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, A Significance Determination of Reactor Inspection Findings for At-Power Situations, and determined it to be of very low safety significance (Green) because it was not associated with a design or qualification deficiency, it did not represent any actual loss of a system safety function, it did not represent the actual loss of a safety function of a single train for greater than its Technical Specification allowed outage time, and it was not potentially risk significant due to a seismic, flooding, or severe weather initiating event.

Inspection Report# : [2007004 \(pdf\)](#)

Significance:  Jul 20, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to maintain adequate design basis calculations for safety-related motors.

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The team determined that Entergy did not maintain appropriate design basis calculations to ensure that the safety-related motors for the emergency service water (ESW) and standby liquid control (SLC) pumps had adequate starting voltage.

The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of the ESW and SLC systems to respond to initiating events to prevent undesirable consequences. This finding is of very low significance because it did not result in the loss of operability.

This finding has a cross-cutting aspect in the area of human performance (Resources component) because Entergy did not ensure that adequate resources were available to maintain complete, accurate and up-to-date design documentation. (H.2(c))

Inspection Report# : [2007006 \(pdf\)](#)

Significance:  Jul 20, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

EDG FOST capacity calculation did not account for vortexing.

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The team determined that Entergy failed to properly identify and evaluate the potential for vortexing in the emergency diesel generator (EDG) fuel oil transfer pump (FOTP) suction inlet piping. Specifically, Entergy's EDG fuel oil storage tank (FOST) inventory calculation did not include any allowance for suction line submergence to prevent air entrainment resulting from the effects of vortexing.

The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of the EDGs to respond to initiating events to prevent undesirable consequences. This finding is of very low significance because it did not result in the loss of safety function.

This finding has a cross-cutting aspect in the area of problem identification and resolution (PI&R) (Self - and Independent Assessments component) because Entergy did not ensure that design basis self assessments were of sufficient depth, comprehensive, appropriately objective, and self-critical. (P.3(a))

Inspection Report# : [2007006 \(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : June 05, 2008

FitzPatrick

2Q/2008 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: FIN Finding

Surge arresters not replaced in accordance with preventive maintenance program

A self-revealing finding was identified when one of the 115 kV offsite power transformer 71T-3 surge arresters failed in-service. Specifically, Entergy did not adequately implement maintenance program expectations outlined in EN-DC-324, "Preventive Maintenance Program," Revision 4 and ensure replacement of the surge arrester upon exceeding its reliable service life. The surge arrester failure contributed to a loss of offsite power.

The inspectors determined that this finding is more than minor because it is associated with the protection against external factors attribute (grid stability) of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At Power Situations," and determined it to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available.

This finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not take appropriate corrective actions to promptly replace the surge arrester when it was identified to be past its reliable service life. (P.1(d))

Inspection Report# : [2008003 \(pdf\)](#)

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Procedure Associated with Lake Condition Monitoring

A self-revealing NCV of Technical Specification 5.4, "Procedures," was identified when operators did not implement certain steps specified in Operations Shift Standing Order 2007-020, "Lake Condition Monitoring," Revision 4, which increased the likelihood of a scram. Entergy entered the condition into their corrective action program, revised the lake condition monitoring procedure, and discussed procedure adherence expectations with operators.

The inspectors determined that this finding is more than minor because it is associated with the Human Performance attribute (human error) of the Initiating Events cornerstone; and it impacted the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety function during shutdown as well as power operations. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At Power Situation," and determined it to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment functions would not be available.

This finding had a cross-cutting aspect in the area of human performance because Entergy did not ensure that expectations regarding procedural compliance were met. (H.4(b)) (Section 40A3)

Inspection Report# : [2007005 \(pdf\)](#)

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: FIN Finding

Feedwater Low Flow Control Valve Degradation Led to Primary Containment Isolation System Group Two Isolation

A self-revealing finding was identified involving inadequate corrective actions when Entergy failed to correct the adverse condition of the feedwater low-flow control valve, 34FCV-137. Entergy also failed to implement corrective actions in a timely manner to remotely monitor feedwater flow rate through the feedwater low-flow control valve in order to support level control. This condition resulted in a low level scram and primary containment isolation system group two isolation on September 12, 2007, and October 28, 2007. This problem was entered into Entergy's corrective action program. Following the October 28, 2007, manual scram and subsequent low level scram, Entergy replaced the stem and packing box for the low-flow control valve and implemented an interim method to remotely monitor feedwater flow rate. In addition, Entergy has scheduled a design change to provide low-range feedwater flow rate instrumentation in the control room.

The inspectors determined that this finding is more than minor because it is associated with the equipment performance attribute of the Initiating Events cornerstone, and it impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated this finding using Phase 1 of Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not take appropriate corrective actions, in a timely manner, to address the feedwater low-flow control valve degradation and to provide a method to monitor the feedwater control system response following the low level scram and primary containment isolation system group two isolation on September 12, 2007. Consequently, another low level scram and primary containment isolation system group two isolation occurred on October 28, 2007. (P.1(d)) (Section 40A3)

Inspection Report# : [2007005](#) (*pdf*)

Mitigating Systems

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Quality standards not specified in design documents that resulted in deficient B LPCI battery cable bend radii.

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because Entergy did not ensure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, Entergy did not ensure that the cable bend radius for the 'B' low pressure coolant injection (LPCI) battery inter-tier jumper cables was in accordance with the design. Entergy entered the condition into their corrective action program, issued a work request to establish appropriate bend radii and inspected all other batteries for extent of condition.

The inspectors determined that this finding is more than minor because it is associated with the Design Control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, reliability was affected because of additional stresses imposed at the u-bend of the cable which impacts long-term cable reliability. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because the finding represented a design or qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the completeness of the design documents, procedures, and work packages used during the maintenance activities in April 2008, were not sufficiently complete to ensure design standards were implemented. (H.2(c)).

Inspection Report# : [2008003](#) (*pdf*)

Significance: G May 16, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure Guidance to Address Spurious Failures of the RCIC and LPCI Systems

The team identified a Green non-cited violation of technical specification 5.4.1.d for failure to provide adequate procedure directions in Attachment 6 of AOP-28, "Operation During Plant Fires," Rev. 18, for operators to restore the RCIC system and secure the "A" RHR pump from potential fire-induced cable failures. The licensee entered this issue into their corrective action program and implemented procedure changes to provide operators appropriate guidance to address the spurious failures of both RCIC and LPCI "A" systems in the event of fire in fire zone RB-1C.

The finding was more than minor because it affected the procedure quality attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy had not established adequate procedure guidance to restore the RCIC system and secure the "A" RHR pump from fire-induced cable failures in the event of a fire in fire zone RB-1C. The team assessed this finding in accordance with NRC IMC 0609, Appendix F, "Fire Protection Significance Determination Process." This finding screened to very low safety significance (Green) in Phase 1 of the SDP because it was assigned a low degradation rating. The low degradation rating was assigned based on the team's review of the BWR Owners' Group response and walkdowns conducted of procedure AOP-28, "Operation During Plant Fires," Rev. 18. The team concluded that, although a spurious start of the "A" RHR pump with minimum flow condition could occur, an operator would reach the LPCI mode step in the procedure within the maximum expected minimum flow condition evaluated and specified in BWR Owners' Group response of thirty minutes. As a result, a low degradation rating was assigned. (Section 1R05.01)

Inspection Report# : [2008006](#) (*pdf*)

Significance: G Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Risk Assessment When Required by 10 CFR Part 50.65(a)(4)

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy failed to perform a risk assessment prior to commencing performance of Instrument Surveillance Procedure ISP-175A1, "Reactor Containment Cooling Instrument Functional Test/ Calibration." This was due to instrument and control technicians performing the procedure which was not in accordance with the plant work schedule. This problem was entered into Entergy's corrective action program. Corrective actions included communicating the error to personnel, conducting human performance training, and improving administrative control of procedures.

The inspectors determined that the finding impacted the Mitigating Systems cornerstone because it impacted the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding is more than minor because the licensee's risk assessment failed to consider risk significant structures, systems, and components (i.e., high pressure coolant injection and reactor core isolation cooling) that were unavailable during the maintenance period.

Using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP," Flowchart 1, "Assessment of Risk Deficit," the inspectors determined the incremental core damage probability deficit from Entergy's core damage frequency as a result of the actual duration of ISP-175A1 (1.07 hours). The inspectors calculated the incremental core damage probability deficit and determined it to be significantly lower than 1E-6. Because the calculated risk deficit was not greater than 1E-6 incremental core damage probability deficit, the inspectors determined that this finding was of very low safety significance (Green).

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the instrument and control technicians involved did not effectively implement the expected human error prevention techniques (e.g., self-checking, prejob briefs, and proper documentation of activities), to ensure the correct procedure was used in accordance with the work schedule. (H.4(a)) (Section 1R13)

Inspection Report# : [2007005](#) (*pdf*)

Significance: **G** Sep 28, 2007

Identified By: NRC

Item Type: FIN Finding

Failure to correct negative slope of the reactor core isolation cooling system flow instrument sensing lines.

A self-revealing finding was identified involving inadequate corrective actions when Entergy did not correct an adverse condition on the reactor core isolation cooling (RCIC) system flow instrument sensing lines. The condition allowed air bubbles to form in the sensing lines, resulting in an erroneous flow indication. Consequently, the RCIC system would not have been able to achieve its design flow rate of 410 gallons per minute (gpm). Entergy entered the condition into their corrective action program and implemented interim corrective actions by revising the RCIC operating procedure to vent the sensing lines. In addition, Entergy has scheduled activities to correct the instrument sensing line condition.

The inspectors determined that this finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone; and, it impacted the cornerstone objective of ensuring the availability, reliability, and capability of the RCIC system to respond to initiating events to prevent undesirable consequences. Specifically, the RCIC system would not have been able to achieve its design flow rate of 410 gpm. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, ASignificance Determination of Reactor Inspection Findings for At-Power Situations,@ and determined it to be of very low safety significance (Green) because it was not associated with a design or qualification deficiency, it did not represent any actual loss of a system safety function, it did not represent the actual loss of a safety function of a single train for greater than its Technical Specification allowed outage time, and it was not potentially risk significant due to a seismic, flooding, or severe weather initiating event.

Inspection Report# : [2007004](#) (pdf)

Significance: **G** Jul 20, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to maintain adequate design basis calculations for safety-related motors.

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The team determined that Entergy did not maintain appropriate design basis calculations to ensure that the safety-related motors for the emergency service water (ESW) and standby liquid control (SLC) pumps had adequate starting voltage.

The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of the ESW and SLC systems to respond to initiating events to prevent undesirable consequences. This finding is of very low significance because it did not result in the loss of operability.

This finding has a cross-cutting aspect in the area of human performance (Resources component) because Entergy did not ensure that adequate resources were available to maintain complete, accurate and up-to-date design documentation. (H.2(c))

Inspection Report# : [2007006](#) (pdf)

Significance: **G** Jul 20, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

EDG FOST capacity calculation did not account for vortexing.

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The team determined that Entergy failed to properly identify and evaluate the potential for vortexing in the emergency diesel generator (EDG) fuel oil transfer pump (FOTP) suction inlet piping. Specifically, Entergy's EDG fuel oil storage tank (FOST) inventory calculation did not include any allowance for suction line submergence to prevent air entrainment resulting from the effects of vortexing.

The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems

cornerstone objective of ensuring the availability, reliability, and capability of the EDGs to respond to initiating events to prevent undesirable consequences. This finding is of very low significance because it did not result in the loss of safety function.

This finding has a cross-cutting aspect in the area of problem identification and resolution (PI&R) (Self - and Independent Assessments component) because Entergy did not ensure that design basis self assessments were of sufficient depth, comprehensive, appropriately objective, and self-critical. (P.3(a))
Inspection Report# : [2007006](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : August 29, 2008

FitzPatrick

3Q/2008 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: FIN Finding

Surge arresters not replaced in accordance with preventive maintenance program

A self-revealing finding was identified when one of the 115 kV offsite power transformer 71T-3 surge arresters failed in-service. Specifically, Entergy did not adequately implement maintenance program expectations outlined in EN-DC-324, "Preventive Maintenance Program," Revision 4 and ensure replacement of the surge arrester upon exceeding its reliable service life. The surge arrester failure contributed to a loss of offsite power.

The inspectors determined that this finding is more than minor because it is associated with the protection against external factors attribute (grid stability) of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At Power Situations," and determined it to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available.

This finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not take appropriate corrective actions to promptly replace the surge arrester when it was identified to be past its reliable service life. (P.1(d))

Inspection Report# : [2008003](#) (*pdf*)

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Procedure Associated with Lake Condition Monitoring

A self-revealing NCV of Technical Specification 5.4, "Procedures," was identified when operators did not implement certain steps specified in Operations Shift Standing Order 2007-020, "Lake Condition Monitoring," Revision 4, which increased the likelihood of a scram. Entergy entered the condition into their corrective action program, revised the lake condition monitoring procedure, and discussed procedure adherence expectations with operators.

The inspectors determined that this finding is more than minor because it is associated with the Human Performance attribute (human error) of the Initiating Events cornerstone; and it impacted the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety function during shutdown as well as power operations. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At Power Situation," and determined it to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment functions would not be available.

This finding had a cross-cutting aspect in the area of human performance because Entergy did not ensure that expectations regarding procedural compliance were met. (H.4(b)) (Section 4OA3)

Inspection Report# : [2007005](#) (*pdf*)

Significance:  Dec 31, 2007

Identified By: NRC

Item Type: FIN Finding

Feedwater Low Flow Control Valve Degradation Led to Primary Containment Isolation System Group Two Isolation

A self-revealing finding was identified involving inadequate corrective actions when Entergy failed to correct the adverse condition of the feedwater low-flow control valve, 34FCV-137. Entergy also failed to implement corrective actions in a timely manner to remotely monitor feedwater flow rate through the feedwater low-flow control valve in order to support level control. This condition resulted in a low level scram and primary containment isolation system group two isolation on September 12, 2007, and October 28, 2007. This problem was entered into Entergy's corrective action program. Following the October 28, 2007, manual scram and subsequent low level scram, Entergy replaced the stem and packing box for the low-flow control valve and implemented an interim method to remotely monitor feedwater flow rate. In addition, Entergy has scheduled a design change to provide low-range feedwater flow rate instrumentation in the control room.

The inspectors determined that this finding is more than minor because it is associated with the equipment performance attribute of the Initiating Events cornerstone, and it impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated this finding using Phase 1 of Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not take appropriate corrective actions, in a timely manner, to address the feedwater low-flow control valve degradation and to provide a method to monitor the feedwater control system response following the low level scram and primary containment isolation system group two isolation on September 12, 2007. Consequently, another low level scram and primary containment isolation system group two isolation occurred on October 28, 2007. (P.1(d)) (Section 4OA3)

Inspection Report# : [2007005](#) (*pdf*)

Mitigating Systems

Significance:  Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Manage Risk During Maintenance Activity Resulted in Loss of Shutdown Cooling

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy did not manage the increase in risk that resulted from removal of the 'B' reactor protection system from service in preparation for conducting maintenance. The removal of the 'B' reactor protection system from service resulted in an unanticipated loss of shutdown cooling (SDC). Entergy took prompt action to communicate the error to station personnel; provide additional oversight for equipment tagouts affecting required safety systems during the remainder of the refueling outage; and entered the issue into the corrective action program.

This finding is more than minor because it is related to maintenance risk assessment and management. In this instance, Entergy did not implement prescribed significant compensatory measures and effectively manage those measures. Specifically, this finding reflects inadequate risk management that contributed to a short duration loss of shutdown decay heat removal capability resulting from the inadvertent interruption of flow through the operating train of shutdown cooling during cavity flood-up, in preparation for refueling. In accordance with IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Appendix G, "Shutdown Operations Significance Determination Process," the inspectors determined this finding was of very low safety significance (Green). In accordance with IMC 0609, Appendix G, this finding did not require quantification and did not constitute a significant loss of thermal margin, based upon the slow reactor coolant system heat-up rate and minimal time of interruption in shutdown cooling system operation.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not plan and coordinate work activities properly to manage operational impact of work activities. Specifically, the impact on shutdown cooling of deenergizing the 'B' reactor protection system was not recognized or assessed. Additionally, a number of processes and barriers, such as the outage risk assessment and protective equipment program, were not used effectively.

Inspection Report# : [2008004](#) (*pdf*)

Significance:  Aug 01, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

RHR Service Water SOV Corrective Actions

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," because Entergy did not implement adequate corrective actions for the residual heat removal (RHR) service water motor bearing cooling water supply solenoid operated valves (SOVs). Specifically, Entergy did not promptly correct a condition adverse to quality associated with trains of RHR service water motor bearing cooling water supply SOVs following a December 30, 2006 failure of the 'B' RHR service water motor bearing cooling water supply valve. This resulted in unplanned unavailability for the 'C' RHR service water motor on May 4, 2007 due to the failure of the 'C' RHR service water motor bearing cooling water supply valve. Entergy entered this lack of taking prompt corrective action into their corrective action program as CR-JAF-2008-02411. In addition, Entergy replaced the 'B' and 'C' RHR service water motor bearing cooling water supply valves.

This finding was more than minor because it impacted the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability, reliability and capability of a system that responds to initiating events to prevent undesirable consequences. The finding was evaluated in accordance with Inspection Manual Chapter (IMC) 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors conducted a Phase 1 Significance Determination Process (SDP) screening

and determined that the finding was of very low safety significance (Green) because the finding was not a design or qualification deficiency, did not represent a loss of system safety function or loss of a single train for greater than its allowed technical specification time, and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not thoroughly evaluate a condition adverse to quality such that the resolutions addressed the causes and extent of condition, as necessary. Specifically, Entergy's corrective actions following the 2006 SOV failure did not evaluate the in-service condition of the 'A', 'C', and 'D' RHR service water motor bearing cooling water supply valves.

Inspection Report# : [2008008](#) (*pdf*)

G

Significance: Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Quality standards not specified in design documents that resulted in deficient B LPCI battery cable bend radii.

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because Entergy did not ensure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, Entergy did not ensure that the cable bend radius for the 'B' low pressure coolant injection (LPCI) battery inter-tier jumper cables was in accordance with the design. Entergy entered the condition into their corrective action program, issued a work request to establish appropriate bend radii and inspected all other batteries for extent of condition.

The inspectors determined that this finding is more than minor because it is associated with the Design Control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, reliability was affected because of additional stresses imposed at the u-bend of the cable which impacts long-term cable reliability. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because the finding represented a design or qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the completeness of the design documents, procedures, and work packages used during the maintenance activities in April 2008, were not sufficiently complete to ensure design standards were implemented. (H.2(c)).

Inspection Report# : [2008003](#) (*pdf*)

G

Significance: May 16, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure Guidance to Address Spurious Failures of the RCIC and LPCI Systems

The team identified a Green non-cited violation of technical specification 5.4.1.d for failure to provide adequate procedure directions in Attachment 6 of AOP-28, "Operation During Plant Fires," Rev. 18, for operators to restore the RCIC system and secure the "A" RHR pump from potential fire-induced cable failures. The licensee entered this issue into their corrective action program and implemented procedure changes to provide operators appropriate guidance to address the spurious failures of both RCIC and LPCI "A" systems in the event of fire in fire zone RB-1C.

The finding was more than minor because it affected the procedure quality attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy had not established adequate procedure guidance to restore the RCIC system and secure the "A" RHR pump from fire-induced cable failures in the event of a fire in fire zone RB-1C. The team assessed this finding in accordance with NRC IMC 0609, Appendix F, "Fire Protection Significance Determination Process." This finding screened to very low safety significance (Green) in Phase 1 of the SDP because it was assigned a low degradation rating. The low degradation rating was assigned based on the team's review of the BWR Owners' Group response and walkdowns conducted of procedure AOP-28, "Operation During Plant Fires," Rev. 18. The team concluded that, although a spurious start of the "A" RHR pump with minimum flow condition could occur, an operator would reach the LPCI mode step in the procedure within the maximum expected minimum flow condition evaluated and specified in BWR Owners' Group response of thirty minutes. As a result, a low degradation rating was assigned. (Section 1R05.01)

Inspection Report# : [2008006](#) (*pdf*)

G

Significance: Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Risk Assessment When Required by 10 CFR Part 50.65(a)(4)

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy failed to perform a risk assessment prior to commencing performance of Instrument Surveillance

Procedure ISP-175A1, "Reactor Containment Cooling Instrument Functional Test/ Calibration." This was due to instrument and control technicians performing the procedure which was not in accordance with the plant work schedule. This problem was entered into Entergy's corrective action program. Corrective actions included communicating the error to personnel, conducting human performance training, and improving administrative control of procedures.

The inspectors determined that the finding impacted the Mitigating Systems cornerstone because it impacted the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding is more than minor because the licensee's risk assessment failed to consider risk significant structures, systems, and components (i.e., high pressure coolant injection and reactor core isolation cooling) that were unavailable during the maintenance period.

Using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP," Flowchart 1, "Assessment of Risk Deficit," the inspectors determined the incremental core damage probability deficit from Entergy's core damage frequency as a result of the actual duration of ISP-175A1 (1.07 hours). The inspectors calculated the incremental core damage probability deficit and determined it to be significantly lower than 1E-6. Because the calculated risk deficit was not greater than 1E-6 incremental core damage probability deficit, the inspectors determined that this finding was of very low safety significance (Green).

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the instrument and control technicians involved did not effectively implement the expected human error prevention techniques (e.g., self-checking, prejob briefs, and proper documentation of activities), to ensure the correct procedure was used in accordance with the work schedule. (H.4(a)) (Section 1R13)

Inspection Report# : [2007005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: SL-IV Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Make a Written Report of a Non-Conforming Condition Relative to an NRC-Approved Package

A self-revealing NCV of 10 CFR Part 71.95 was identified because Entergy did not provide a written report to the NRC as required by 10 CFR Part 71.95 relative to a non-conforming condition involving the shipment of a NRC-approved package. Entergy was informed that a package it shipped to EnergySolutions™ Barnwell Low Level Radioactive Waste Disposal Facility was found to be in non-conformance with the applicable Certificate of Compliance for the package upon receipt, Entergy did not report the condition to the NRC within 60 days of the occurrence, as required. Failure of Entergy to report the condition, as required by 10 CFR Part 71.95, constitutes a performance deficiency in that the issue is the result of Entergy not meeting a regulatory requirement that was reasonably within Entergy's ability to foresee and correct, and should have been prevented. Entergy entered this issue into the corrective action program as condition report (CR)-2008-02772.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement IV "Transportation," example D4 which states, "a noncompliance with shipping papers, marking, labeling, placarding, packaging or loading not amounting to a Severity Level I, II, or III violation;" the NRC determined this violation is categorized as a SL IV Violation. The Enforcement Policy Supplement I "Reactor Operations" examples D3, D4, and D5 are similar to this issue, in that they discuss examples of failures to make required reports for more than minor events, which are also categorized at Severity Level IV.

This finding has a cross-cutting aspect in the area of problem identification and resolution related - corrective action program, because Entergy performed an insufficient evaluation of a non-conforming condition associated with an NRC-approved package to assure the matter was properly classified, prioritized and evaluated relative to reportability.

Inspection Report# : [2008004](#) (*pdf*)

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : November 26, 2008

FitzPatrick

4Q/2008 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: FIN Finding

Surge arresters not replaced in accordance with preventive maintenance program

A self-revealing finding was identified when one of the 115 kV offsite power transformer 71T-3 surge arresters failed in-service. Specifically, Entergy did not adequately implement maintenance program expectations outlined in EN-DC-324, "Preventive Maintenance Program," Revision 4 and ensure replacement of the surge arrester upon exceeding its reliable service life. The surge arrester failure contributed to a loss of offsite power.

The inspectors determined that this finding is more than minor because it is associated with the protection against external factors attribute (grid stability) of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At Power Situations," and determined it to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available.

This finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not take appropriate corrective actions to promptly replace the surge arrester when it was identified to be past its reliable service life. (P.1(d))

Inspection Report# : [2008003](#) (*pdf*)

Mitigating Systems

Significance:  Dec 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Quality Standards Not Specified in Design Documents that Resulted in Unsupported HPCI Oil Tubing

An NRC identified NCV of 10 CFR 50 Appendix B, Criterion III, "Design Control," was identified when Entergy did not assure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, Entergy did not ensure the oil tubing within the high pressure coolant injection (HPCI) system remained properly supported and routed with an appropriate slope in accordance with design. The issue was entered into Entergy's corrective action program as CR-JAF-2008-04040. Corrective actions included establishing work order 172913 to restore the original configuration properly supporting the HPCI tubing lines.

This finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, reliability was affected because the unsupported span of tubing was more susceptible to personnel damage and vibration during HPCI operation, both during surveillance testing and also if called upon to perform its safety function. In addition, the tubing was more susceptible to damage and adverse routing changes during maintenance activities. Therefore, over time, the high

pressure fittings associated with the lines would be more likely to suffer failures, retain air bubbles within the lines, and/or leak during pump operation affecting the long-term reliability of the system. This was reasonably within Entergy's ability to foresee and prevent because the governing procedures require tube routings, including support locations, be provided during installation of Class I tubing, and a support bracket was available to attach the tubing. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because the finding represented a design or qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the design documents, procedures, and work packages used during the maintenance activities in September and October 2008, were not sufficiently complete to ensure design standards were implemented.

Inspection Report# : [2008005](#) (pdf)

Significance:  Dec 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Conduct of Relay Test Without Plant Impact Review Resulted in Loss of Emergency Bus and Shutdown Cooling

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy did not manage the increase in risk during the conduct of relay testing associated with emergency buses. The conduct of the relay testing resulted in an unanticipated loss of shutdown cooling (SDC) function. Entergy implemented corrective actions that included communicating the error to personnel to reinforce management expectations for control of protected equipment and providing an additional level of work authorization review.

This finding is more than minor because it is associated with the Mitigating Systems cornerstone and is related to Entergy's performance in assessing and managing risk. A risk assessment review was not conducted prior to performance of a trip and lockout relay functional test associated with emergency buses. Specifically, this finding reflects inadequate risk management that contributed to a short duration loss of shutdown decay heat removal capability resulting from the inadvertent interruption of flow through the operating train of shutdown cooling with the plant in a cold shutdown condition. This was reasonably within Entergy's ability to foresee and prevent because there were opportunities to recognize and manage the potential risk of losing shutdown cooling and to schedule the maintenance activity at a more appropriate maintenance window or take actions to prevent the loss of shutdown cooling.

In accordance with IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Appendix G, "Shutdown Operations Significance Determination Process," the inspectors determined that this finding was of very low safety significance (Green). The basis for this determination is that in accordance with IMC 0609, Appendix G, Table 1, "Losses of Control," and Checklist 8, "BWR Cold Shutdown or Refueling Operation Time to Boil > 2 Hours: RCS Level <23 feet Above Top of Flange," this finding did not require quantification and did not constitute a significant loss of thermal margin, based upon the slow reactor coolant system heat-up rate and minimal time of interruption in shutdown cooling system operation. The problem was entered into Entergy's corrective action program as CR-JAF-2008-03805.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not plan and coordinate work activities properly to manage the operational impact of work activities. Specifically, Entergy did not recognize that the emergency bus 10600 would be de-energized as a result of the trip and lockout relay functional test.

Inspection Report# : [2008005](#) (pdf)

Significance:  Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Manage Risk During Maintenance Activity Resulted in Loss of Shutdown Cooling

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy did not manage the increase in risk that resulted from removal of the 'B' reactor protection system from service in preparation for conducting maintenance. The removal of the 'B' reactor protection system from service resulted in an unanticipated loss of shutdown cooling (SDC). Entergy took prompt action to communicate the error to station personnel; provide additional oversight for equipment tagouts affecting required safety systems during the remainder of the refueling outage; and entered the issue into the corrective action program.

This finding is more than minor because it is related to maintenance risk assessment and management. In this instance, Entergy did not implement prescribed significant compensatory measures and effectively manage those measures. Specifically, this finding reflects inadequate risk management that contributed to a short duration loss of shutdown decay heat removal capability resulting from the inadvertent interruption of flow through the operating train of shutdown cooling during cavity flood-up, in preparation for refueling. In accordance with IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Appendix G, "Shutdown Operations Significance Determination Process," the inspectors determined this finding was of very low safety significance (Green). In accordance with IMC 0609, Appendix G, this finding did not require quantification and did not constitute a significant loss of thermal margin, based upon the slow reactor coolant system heat-up rate and minimal time of interruption in shutdown cooling system operation.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not plan and coordinate work activities properly to manage operational impact of work activities. Specifically, the impact on shutdown cooling of deenergizing the 'B' reactor protection system was not recognized or assessed. Additionally, a number of processes and barriers, such as the outage risk assessment and protective equipment program, were not used effectively.

Inspection Report# : [2008004](#) (pdf)

G

Significance: Aug 01, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

RHR Service Water SOV Corrective Actions

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," because Entergy did not implement adequate corrective actions for the residual heat removal (RHR) service water motor bearing cooling water supply solenoid operated valves (SOVs). Specifically, Entergy did not promptly correct a condition adverse to quality associated with trains of RHR service water motor bearing cooling water supply SOVs following a December 30, 2006 failure of the 'B' RHR service water motor bearing cooling water supply valve. This resulted in unplanned unavailability for the 'C' RHR service water motor on May 4, 2007 due to the failure of the 'C' RHR service water motor bearing cooling water supply valve. Entergy entered this lack of taking prompt corrective action into their corrective action program as CR-JAF-2008-02411. In addition, Entergy replaced the 'B' and 'C' RHR service water motor bearing cooling water supply valves.

This finding was more than minor because it impacted the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability, reliability and capability of a system that responds to initiating events to prevent undesirable consequences. The finding was evaluated in accordance with Inspection Manual Chapter (IMC) 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors conducted a Phase 1 Significance Determination Process (SDP) screening and determined that the finding was of very low safety significance (Green) because the finding was not a design or qualification deficiency, did not represent a loss of system safety function or loss of a single train for greater than its allowed technical specification time, and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not thoroughly evaluate a condition adverse to quality such that the resolutions

addressed the causes and extent of condition, as necessary. Specifically, Entergy's corrective actions following the 2006 SOV failure did not evaluate the in-service condition of the 'A', 'C', and 'D' RHR service water motor bearing cooling water supply valves.

Inspection Report# : [2008008](#) (*pdf*)

G

Significance: Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Quality standards not specified in design documents that resulted in deficient B LPCI battery cable bend radii.

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because Entergy did not ensure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, Entergy did not ensure that the cable bend radius for the 'B' low pressure coolant injection (LPCI) battery inter-tier jumper cables was in accordance with the design. Entergy entered the condition into their corrective action program, issued a work request to establish appropriate bend radii and inspected all other batteries for extent of condition.

The inspectors determined that this finding is more than minor because it is associated with the Design Control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, reliability was affected because of additional stresses imposed at the u-bend of the cable which impacts long-term cable reliability. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because the finding represented a design or qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the completeness of the design documents, procedures, and work packages used during the maintenance activities in April 2008, were not sufficiently complete to ensure design standards were implemented. (H.2(c)).

Inspection Report# : [2008003](#) (*pdf*)

G

Significance: May 16, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure Guidance to Address Spurious Failures of the RCIC and LPCI Systems

The team identified a Green non-cited violation of technical specification 5.4.1.d for failure to provide adequate procedure directions in Attachment 6 of AOP-28, "Operation During Plant Fires," Rev. 18, for operators to restore the RCIC system and secure the "A" RHR pump from potential fire-induced cable failures. The licensee entered this issue into their corrective action program and implemented procedure changes to provide operators appropriate guidance to address the spurious failures of both RCIC and LPCI "A" systems in the event of fire in fire zone RB-1C.

The finding was more than minor because it affected the procedure quality attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy had not established adequate procedure guidance to restore the RCIC system and secure the "A" RHR pump from fire-induced cable failures in the event of a fire in fire zone RB-1C. The team assessed this finding in accordance with NRC IMC 0609, Appendix F, "Fire Protection Significance Determination Process." This finding screened to very low safety significance (Green) in Phase 1 of the SDP because it was assigned a low degradation rating. The low degradation rating was assigned based on the team's review of the BWR Owners' Group response and walkdowns conducted of procedure AOP-28, "Operation During Plant Fires," Rev. 18. The team concluded that, although a spurious start of the "A" RHR pump with minimum flow condition could occur, an operator would reach the LPCI mode step in the procedure within the maximum expected minimum flow condition evaluated and specified in BWR Owners' Group response of thirty minutes. As a result, a low degradation rating was assigned. (Section 1R05.01)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: SL-IV Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Make a Written Report of a Non-Conforming Condition Relative to an NRC-Approved Package

A self-revealing NCV of 10 CFR Part 71.95 was identified because Entergy did not provide a written report to the NRC as required by 10 CFR Part 71.95 relative to a non-conforming condition involving the shipment of a NRC-approved package. Entergy was informed that a package it shipped to EnergySolutions™ Barnwell Low Level Radioactive Waste Disposal Facility was found to be in non-conformance with the applicable Certificate of Compliance for the package upon receipt, Entergy did not report the condition to the NRC within 60 days of the occurrence, as required. Failure of Entergy to report the condition, as required by 10 CFR Part 71.95, constitutes a performance deficiency in that the issue is the result of Entergy not meeting a regulatory requirement that was reasonably within Entergy's ability to foresee and correct, and should have been prevented. Entergy entered this issue into the corrective action program as condition report (CR)-2008-02772.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement IV "Transportation," example D4 which states, "a noncompliance with shipping papers, marking, labeling, placarding, packaging or loading not amounting to a Severity Level I, II, or III violation;" the NRC determined this violation is categorized as a SL IV Violation. The Enforcement Policy Supplement I "Reactor Operations" examples D3, D4, and D5 are similar to this issue, in that they discuss examples of failures to make required reports for more than minor events, which are also categorized at Severity Level IV.

This finding has a cross-cutting aspect in the area of problem identification and resolution related - corrective action program, because Entergy performed an insufficient evaluation of a non-conforming condition associated with an NRC-approved package to assure the matter was properly classified, prioritized and evaluated relative to reportability.

Inspection Report# : [2008004](#) (pdf)

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not

provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : April 07, 2009

FitzPatrick

1Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: FIN Finding

Surge arresters not replaced in accordance with preventive maintenance program

A self-revealing finding was identified when one of the 115 kV offsite power transformer 71T-3 surge arresters failed in-service. Specifically, Entergy did not adequately implement maintenance program expectations outlined in EN-DC-324, "Preventive Maintenance Program," Revision 4 and ensure replacement of the surge arrester upon exceeding its reliable service life. The surge arrester failure contributed to a loss of offsite power.

The inspectors determined that this finding is more than minor because it is associated with the protection against external factors attribute (grid stability) of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At Power Situations," and determined it to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available.

This finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not take appropriate corrective actions to promptly replace the surge arrester when it was identified to be past its reliable service life. (P.1(d))

Inspection Report# : [2008003](#) (*pdf*)

Mitigating Systems

Significance: SL-IV Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failed to Submit an LER For a Condition Prohibited by TS Associated With EDG Fuel Oil Supply

The inspectors identified a Severity Level IV, non-cited violation (NCV) because Entergy did not provide a written 60-day report to the NRC as required by 10 CFR 50.73 relative to a condition which was prohibited by Technical Specifications (TS) 3.8.3. Specifically, on several occasions between September 2006 and July 2007 the volume for either the 'A' or 'B' fuel oil storage tanks (FOST) was such that there was an insufficient quantity of fuel oil to provide a seven day fuel oil supply for the associated emergency diesel generator (EDG) as required per Technical Specifications. Entergy personnel, in determining past reportability, improperly credited the associated fuel oil day tank towards the seven day supply and erroneously concluded on September 18, 2007, that the issue was not reportable. Entergy's corrective actions included initiation of CR-JAF-2008-04323 and issuance of licensee event report (LER) 2009-001, "Inadequate Engineering Calculation Results in Insufficient Inventory in EDG Fuel Oil Storage Tanks." In addition, Entergy revised applicable procedures to ensure the fuel oil storage tanks contain adequate fuel oil inventory to remain in compliance with the TS.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using the traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement I, "Reactor Operations," example D4 which states,

“A failure to make a required LER;” the NRC determined this violation is more than minor and categorized as a Severity Level IV violation.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution related to the evaluation component because Entergy personnel did not properly consider the TS basis and, therefore, did not properly evaluate the reportability for the EDG FOSTs.

Inspection Report# : [2009002](#) (*pdf*)

Significance:  Dec 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Quality Standards Not Specified in Design Documents that Resulted in Unsupported HPCI Oil Tubing

An NRC identified NCV of 10 CFR 50 Appendix B, Criterion III, “Design Control,” was identified when Entergy did not assure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, Entergy did not ensure the oil tubing within the high pressure coolant injection (HPCI) system remained properly supported and routed with an appropriate slope in accordance with design. The issue was entered into Entergy’s corrective action program as CR-JAF-2008-04040. Corrective actions included establishing work order 172913 to restore the original configuration properly supporting the HPCI tubing lines.

This finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, reliability was affected because the unsupported span of tubing was more susceptible to personnel damage and vibration during HPCI operation, both during surveillance testing and also if called upon to perform its safety function. In addition, the tubing was more susceptible to damage and adverse routing changes during maintenance activities. Therefore, over time, the high pressure fittings associated with the lines would be more likely to suffer failures, retain air bubbles within the lines, and/or leak during pump operation affecting the long-term reliability of the system. This was reasonably within Entergy’s ability to foresee and prevent because the governing procedures require tube routings, including support locations, be provided during installation of Class I tubing, and a support bracket was available to attach the tubing. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, “Significance Determination of Reactor Inspection Findings for At-Power Situations,” and determined it to be of very low safety significance (Green) because the finding represented a design or qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the design documents, procedures, and work packages used during the maintenance activities in September and October 2008, were not sufficiently complete to ensure design standards were implemented.

Inspection Report# : [2008005](#) (*pdf*)

Significance:  Dec 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Conduct of Relay Test Without Plant Impact Review Resulted in Loss of Emergency Bus and Shutdown Cooling

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), “Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants,” was identified when Entergy did not manage the increase in risk during the conduct of relay testing associated with emergency buses. The conduct of the relay testing resulted in an unanticipated loss of shutdown cooling (SDC) function. Entergy implemented corrective actions that included communicating the error to personnel to reinforce management expectations for control of protected equipment and providing an additional level of work authorization review.

This finding is more than minor because it is associated with the Mitigating Systems cornerstone and is related to

Entergy's performance in assessing and managing risk. A risk assessment review was not conducted prior to performance of a trip and lockout relay functional test associated with emergency buses. Specifically, this finding reflects inadequate risk management that contributed to a short duration loss of shutdown decay heat removal capability resulting from the inadvertent interruption of flow through the operating train of shutdown cooling with the plant in a cold shutdown condition. This was reasonably within Entergy's ability to foresee and prevent because there were opportunities to recognize and manage the potential risk of losing shutdown cooling and to schedule the maintenance activity at a more appropriate maintenance window or take actions to prevent the loss of shutdown cooling.

In accordance with IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Appendix G, "Shutdown Operations Significance Determination Process," the inspectors determined that this finding was of very low safety significance (Green). The basis for this determination is that in accordance with IMC 0609, Appendix G, Table 1, "Losses of Control," and Checklist 8, "BWR Cold Shutdown or Refueling Operation Time to Boil > 2 Hours: RCS Level <23 feet Above Top of Flange," this finding did not require quantification and did not constitute a significant loss of thermal margin, based upon the slow reactor coolant system heat-up rate and minimal time of interruption in shutdown cooling system operation. The problem was entered into Entergy's corrective action program as CR-JAF-2008-03805.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not plan and coordinate work activities properly to manage the operational impact of work activities. Specifically, Entergy did not recognize that the emergency bus 10600 would be de-energized as a result of the trip and lockout relay functional test.

Inspection Report# : [2008005](#) (*pdf*)

Significance:  Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Manage Risk During Maintenance Activity Resulted in Loss of Shutdown Cooling

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy did not manage the increase in risk that resulted from removal of the 'B' reactor protection system from service in preparation for conducting maintenance. The removal of the 'B' reactor protection system from service resulted in an unanticipated loss of shutdown cooling (SDC). Entergy took prompt action to communicate the error to station personnel; provide additional oversight for equipment tagouts affecting required safety systems during the remainder of the refueling outage; and entered the issue into the corrective action program.

This finding is more than minor because it is related to maintenance risk assessment and management. In this instance, Entergy did not implement prescribed significant compensatory measures and effectively manage those measures. Specifically, this finding reflects inadequate risk management that contributed to a short duration loss of shutdown decay heat removal capability resulting from the inadvertent interruption of flow through the operating train of shutdown cooling during cavity flood-up, in preparation for refueling. In accordance with IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Appendix G, "Shutdown Operations Significance Determination Process," the inspectors determined this finding was of very low safety significance (Green). In accordance with IMC 0609, Appendix G, this finding did not require quantification and did not constitute a significant loss of thermal margin, based upon the slow reactor coolant system heat-up rate and minimal time of interruption in shutdown cooling system operation.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not plan and coordinate work activities properly to manage operational impact of work activities. Specifically, the impact on shutdown cooling of deenergizing the 'B' reactor protection system was not recognized or assessed. Additionally, a number of processes and barriers, such as the outage risk assessment and protective equipment program, were not used effectively.

Inspection Report# : [2008004](#) (*pdf*)

Significance:  Aug 01, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

RHR Service Water SOV Corrective Actions

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," because Entergy did not implement adequate corrective actions for the residual heat removal (RHR) service water motor bearing cooling water supply solenoid operated valves (SOVs). Specifically, Entergy did not promptly correct a condition adverse to quality associated with trains of RHR service water motor bearing cooling water supply SOVs following a December 30, 2006 failure of the 'B' RHR service water motor bearing cooling water supply valve. This resulted in unplanned unavailability for the 'C' RHR service water motor on May 4, 2007 due to the failure of the 'C' RHR service water motor bearing cooling water supply valve. Entergy entered this lack of taking prompt corrective action into their corrective action program as CR-JAF-2008-02411. In addition, Entergy replaced the 'B' and 'C' RHR service water motor bearing cooling water supply valves.

This finding was more than minor because it impacted the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability, reliability and capability of a system that responds to initiating events to prevent undesirable consequences. The finding was evaluated in accordance with Inspection Manual Chapter (IMC) 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors conducted a Phase 1 Significance Determination Process (SDP) screening and determined that the finding was of very low safety significance (Green) because the finding was not a design or qualification deficiency, did not represent a loss of system safety function or loss of a single train for greater than its allowed technical specification time, and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not thoroughly evaluate a condition adverse to quality such that the resolutions addressed the causes and extent of condition, as necessary. Specifically, Entergy's corrective actions following the 2006 SOV failure did not evaluate the in-service condition of the 'A', 'C', and 'D' RHR service water motor bearing cooling water supply valves.

Inspection Report# : [2008008](#) (*pdf*)

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Quality standards not specified in design documents that resulted in deficient B LPCI battery cable bend radii.

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because Entergy did not ensure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, Entergy did not ensure that the cable bend radius for the 'B' low pressure coolant injection (LPCI) battery inter-tier jumper cables was in accordance with the design. Entergy entered the condition into their corrective action program, issued a work request to establish appropriate bend radii and inspected all other batteries for extent of condition.

The inspectors determined that this finding is more than minor because it is associated with the Design Control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, reliability was affected because of additional stresses imposed at the u-bend of the cable which impacts long-term cable reliability. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because the finding represented a design or qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the completeness of the design documents, procedures, and work packages used during the maintenance activities in April

2008, were not sufficiently complete to ensure design standards were implemented. (H.2(c)).

Inspection Report# : [2008003](#) (*pdf*)

G

Significance: May 16, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure Guidance to Address Spurious Failures of the RCIC and LPCI Systems

The team identified a Green non-cited violation of technical specification 5.4.1.d for failure to provide adequate procedure directions in Attachment 6 of AOP-28, "Operation During Plant Fires," Rev. 18, for operators to restore the RCIC system and secure the "A" RHR pump from potential fire-induced cable failures. The licensee entered this issue into their corrective action program and implemented procedure changes to provide operators appropriate guidance to address the spurious failures of both RCIC and LPCI "A" systems in the event of fire in fire zone RB-1C.

The finding was more than minor because it affected the procedure quality attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy had not established adequate procedure guidance to restore the RCIC system and secure the "A" RHR pump from fire-induced cable failures in the event of a fire in fire zone RB-1C. The team assessed this finding in accordance with NRC IMC 0609, Appendix F, "Fire Protection Significance Determination Process." This finding screened to very low safety significance (Green) in Phase 1 of the SDP because it was assigned a low degradation rating. The low degradation rating was assigned based on the team's review of the BWR Owners' Group response and walkdowns conducted of procedure AOP-28, "Operation During Plant Fires," Rev. 18. The team concluded that, although a spurious start of the "A" RHR pump with minimum flow condition could occur, an operator would reach the LPCI mode step in the procedure within the maximum expected minimum flow condition evaluated and specified in BWR Owners' Group response of thirty minutes. As a result, a low degradation rating was assigned. (Section 1R05.01)

Inspection Report# : [2008006](#) (*pdf*)

Barrier Integrity

G

Significance: Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inoperable Control Room Envelope Door

The inspectors identified an NCV of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," because Entergy did not identify and correct a condition adverse to quality related to a control room envelope boundary door. Specifically, on several occasions, Entergy did not identify and implement adequate actions to ensure a control room envelope boundary door, 70DOR-A-300-5, remained latched and able to perform its safety function. Entergy implemented corrective actions which included repair of the latching mechanism to improve the reliability of the door and initiated condition reports CR-JAF-2009-01021 and CR-JAF-2009-01070.

This finding was greater than minor because it affected the barrier integrity attribute of structures, systems, components, and barrier performance under maintaining radiological barrier functionality of the control room and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect operators in the control room from radionuclide releases caused by accidents or events. The finding was evaluated using the SDP Phase I and Phase III because the finding represented a degradation of the barrier function provided for the control room against toxic atmosphere and smoke as well as radiological conditions. The finding was determined to be of very low safety significance, because the amount of time the door was unlatched and ajar was limited to 51 days and, considering the TS allowed outage time of 90 days, the maximum potential time of 51 days represented very low safety significance considering the low probability of a design basis accident during this time period.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution related to the identification component because Entergy personnel did not identify the degraded condition completely and did not recognize the impact that the degraded CRE boundary door had on the control room envelope.

Inspection Report# : [2009002](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: SL-IV Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Make a Written Report of a Non-Conforming Condition Relative to an NRC-Approved Package

A self-revealing NCV of 10 CFR Part 71.95 was identified because Entergy did not provide a written report to the NRC as required by 10 CFR Part 71.95 relative to a non-conforming condition involving the shipment of a NRC-approved package. Entergy was informed that a package it shipped to EnergySolutions™ Barnwell Low Level Radioactive Waste Disposal Facility was found to be in non-conformance with the applicable Certificate of Compliance for the package upon receipt, Entergy did not report the condition to the NRC within 60 days of the occurrence, as required. Failure of Entergy to report the condition, as required by 10 CFR Part 71.95, constitutes a performance deficiency in that the issue is the result of Entergy not meeting a regulatory requirement that was reasonably within Entergy's ability to foresee and correct, and should have been prevented. Entergy entered this issue into the corrective action program as condition report (CR)-2008-02772.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement IV "Transportation," example D4 which states, "a noncompliance with shipping papers, marking, labeling, placarding, packaging or loading not amounting to a Severity Level I, II, or III violation;" the NRC determined this violation is categorized as a SL IV Violation. The Enforcement Policy Supplement I "Reactor Operations" examples D3, D4, and D5 are similar to this issue, in that they discuss examples of failures to make required reports for more than minor events, which are also categorized at Severity Level IV.

This finding has a cross-cutting aspect in the area of problem identification and resolution related - corrective action program, because Entergy performed an insufficient evaluation of a non-conforming condition associated with an NRC-approved package to assure the matter was properly classified, prioritized and evaluated relative to reportability.

Inspection Report# : [2008004](#) (*pdf*)

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : May 28, 2009

FitzPatrick

2Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

High Energy Line Break Door Missing Lower Support

The inspectors identified an NCV of very low safety significance of 10 CFR 50, Appendix B, Criterion III, "Design Control," because Entergy personnel did not maintain a high energy line break (HELB) barrier. Specifically, HELB door 76 FDR-DG-272-11, located between the 'A' division emergency diesel generator (EDG) switchgear room and the turbine building was in use as a HELB barrier but was not qualified due to a missing support. The issue was entered into Entergy's corrective program as condition report (CR)-JAF-2009-01895. Corrective actions included installing a lower bottom right side support to enable the door to be qualified for HELB.

This finding is greater than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, Entergy's engineering calculation previously documented that the door could not be qualified with a missing lower support. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding was determined to be of very low safety significance (Green) because the finding was a qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding has a cross-cutting aspect in the area of human performance within the work practices component because Entergy personnel did not ensure that the secondary HELB barrier was qualified as a result of ineffective error prevention techniques. (H.4(a))

Inspection Report# : [2009003](#) (*pdf*)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Recognize an Adverse HPCI Performance Trend.

A self-revealing NCV of very low safety significance of 10 CFR 50.55a, "Codes and Standards," was identified because Entergy personnel did not comply with the in-service testing (IST) program requirements contained within the applicable American Society of Mechanical Engineers (ASME) Code for Operation and Maintenance of Nuclear Power Plants. Specifically, Entergy personnel changed the reference value for the stroke time of the 23HOV-1, high pressure coolant injection (HPCI) turbine stop valve, without meeting the required ASME code criteria. Entergy's corrective actions included replacing the relay valve piston, lapping the relay valve seat, implementing procedure changes requiring additional evaluation within a decreased range of stroke times to open, and performing an extent of condition review of the IST program.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not

identify a prior adverse performance trend which resulted in an unplanned extension of the maintenance period for the HPCI system, extending the unavailable period from January 23, 2009 through January 31, 2009. The inspectors determined that the finding was of very low safety significance (Green) using the SDP Phase 3, in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations."

The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the resources component because Entergy personnel did not ensure that the procedures and other resources available for inspecting 23HOV-1 and evaluating its performance under the IST program were adequate to assure nuclear safety. (H.2(c))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Balance Chamber Pressure for the HPCI Turbine Stop Valve Was Not Set at a Value to Ensure HPCI Operation

A self-revealing NCV of very low safety significance of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified because Entergy personnel did not identify and correct a condition adverse to quality related to the HPCI system which caused the system to be inoperable between January 30 and April 28, 2009. Specifically, the balance chamber pressure for the HPCI turbine stop valve, 23 HOV-1, was not set at a value to ensure proper operation of the HPCI turbine system and resulted in a HPCI high steam flow isolation during the performance of the surveillance test. Entergy personnel entered the condition into their corrective action program as CR-JAF-2009-01398. Corrective actions included the performance of a root cause analysis, adjustment of the balance chamber pressure to be higher in the acceptance band consistent with operating experience and increasing the frequency of HPCI surveillance testing.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not take adequate corrective action to establish the balance chamber pressure for 23 HOV-1, following an erratic fast opening of the valve on January 30, 2009. The inspectors determined that the finding was of very low safety significance (Green) using the SDP Phase 3, in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations."

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance within the decision-making component because after reviewing the available data and industry operating experience, in January 2009, Entergy personnel incorrectly determined that balance chamber pressure margin was not a contributing cause of the erratic operation of the valve. (H.1(b))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Recognize an Adverse EDG Rotor Insulation Performance Trend.

A self-revealing NCV of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," was identified because Entergy personnel did not identify and correct a condition adverse to quality related to the emergency diesel generator (EDG) system. Specifically, Entergy personnel did not properly identify and implement adequate actions required by their system monitoring program in response to a degraded generator rotor on the 'C' EDG revealed by an adverse performance trend with respect to the insulation resistance and polarization index. Entergy staff initiated CR-JAF-2009-01847 to determine the root causes and recommend further corrective actions. Entergy's corrective actions included rewinding of the affected pole of the 'C' EDG rotor.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating

Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not identify an adverse performance trend which resulted in an unplanned extension of the maintenance period for the 'C' EDG, extending the unavailable period from May 28 through June 11, 2009. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined the finding was of very low safety significance (Green) because the finding was not a qualification or design deficiency, did not represent a loss of a safety function, and did not screen as potentially risk significant due to external initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy personnel did not implement a corrective action program with a low threshold for identifying issues in that the adverse trend in the 'C' EDG rotor insulation was not identified. (P.1(a))

Inspection Report# : [2009003](#) (*pdf*)

Significance: SL-IV Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failed to Submit an LER For a Condition Prohibited by TS Associated With EDG Fuel Oil Supply

The inspectors identified a Severity Level IV, non-cited violation (NCV) because Entergy did not provide a written 60-day report to the NRC as required by 10 CFR 50.73 relative to a condition which was prohibited by Technical Specifications (TS) 3.8.3. Specifically, on several occasions between September 2006 and July 2007 the volume for either the 'A' or 'B' fuel oil storage tanks (FOST) was such that there was an insufficient quantity of fuel oil to provide a seven day fuel oil supply for the associated emergency diesel generator (EDG) as required per Technical Specifications. Entergy personnel, in determining past reportability, improperly credited the associated fuel oil day tank towards the seven day supply and erroneously concluded on September 18, 2007, that the issue was not reportable. Entergy's corrective actions included initiation of CR-JAF-2008-04323 and issuance of licensee event report (LER) 2009-001, "Inadequate Engineering Calculation Results in Insufficient Inventory in EDG Fuel Oil Storage Tanks." In addition, Entergy revised applicable procedures to ensure the fuel oil storage tanks contain adequate fuel oil inventory to remain in compliance with the TS.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using the traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement I, "Reactor Operations," example D4 which states, "A failure to make a required LER," the NRC determined this violation is more than minor and categorized as a Severity Level IV violation.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution related to the evaluation component because Entergy personnel did not properly consider the TS basis and, therefore, did not properly evaluate the reportability for the EDG FOSTs.

Inspection Report# : [2009002](#) (*pdf*)

Significance:  Dec 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Quality Standards Not Specified in Design Documents that Resulted in Unsupported HPCI Oil Tubing

An NRC identified NCV of 10 CFR 50 Appendix B, Criterion III, "Design Control," was identified when Entergy did not assure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, Entergy did not ensure the oil tubing within the high pressure coolant injection (HPCI) system remained properly supported and routed with an appropriate slope in accordance with design. The issue was entered into Entergy's corrective action program as CR-JAF-2008-04040. Corrective actions included establishing work order 172913 to restore the original configuration properly supporting the HPCI tubing lines.

This finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, reliability was affected because the unsupported span of tubing was more susceptible to personnel damage and vibration during HPCI operation, both during surveillance testing and also if called upon to perform its safety function. In addition, the tubing was more susceptible to damage and adverse routing changes during maintenance activities. Therefore, over time, the high pressure fittings associated with the lines would be more likely to suffer failures, retain air bubbles within the lines, and/or leak during pump operation affecting the long-term reliability of the system. This was reasonably within Entergy's ability to foresee and prevent because the governing procedures require tube routings, including support locations, be provided during installation of Class I tubing, and a support bracket was available to attach the tubing. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because the finding represented a design or qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the design documents, procedures, and work packages used during the maintenance activities in September and October 2008, were not sufficiently complete to ensure design standards were implemented.

Inspection Report# : [2008005](#) (*pdf*)

G

Significance: Dec 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Conduct of Relay Test Without Plant Impact Review Resulted in Loss of Emergency Bus and Shutdown Cooling

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy did not manage the increase in risk during the conduct of relay testing associated with emergency buses. The conduct of the relay testing resulted in an unanticipated loss of shutdown cooling (SDC) function. Entergy implemented corrective actions that included communicating the error to personnel to reinforce management expectations for control of protected equipment and providing an additional level of work authorization review.

This finding is more than minor because it is associated with the Mitigating Systems cornerstone and is related to Entergy's performance in assessing and managing risk. A risk assessment review was not conducted prior to performance of a trip and lockout relay functional test associated with emergency buses. Specifically, this finding reflects inadequate risk management that contributed to a short duration loss of shutdown decay heat removal capability resulting from the inadvertent interruption of flow through the operating train of shutdown cooling with the plant in a cold shutdown condition. This was reasonably within Entergy's ability to foresee and prevent because there were opportunities to recognize and manage the potential risk of losing shutdown cooling and to schedule the maintenance activity at a more appropriate maintenance window or take actions to prevent the loss of shutdown cooling.

In accordance with IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Appendix G, "Shutdown Operations Significance Determination Process," the inspectors determined that this finding was of very low safety significance (Green). The basis for this determination is that in accordance with IMC 0609, Appendix G, Table 1, "Losses of Control," and Checklist 8, "BWR Cold Shutdown or Refueling Operation Time to Boil > 2 Hours: RCS Level <23 feet Above Top of Flange," this finding did not require quantification and did not constitute a significant loss of thermal margin, based upon the slow reactor coolant system heat-up rate and minimal time of interruption in shutdown cooling system operation. The problem was entered into Entergy's corrective action program as CR-JAF-2008-03805.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not plan and coordinate work activities properly to manage the operational impact of work activities. Specifically, Entergy did not recognize that the emergency bus 10600 would be de-energized as a result of the trip and lockout relay functional test.

Inspection Report# : [2008005](#) (pdf)

G

Significance: Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Manage Risk During Maintenance Activity Resulted in Loss of Shutdown Cooling

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy did not manage the increase in risk that resulted from removal of the 'B' reactor protection system from service in preparation for conducting maintenance. The removal of the 'B' reactor protection system from service resulted in an unanticipated loss of shutdown cooling (SDC). Entergy took prompt action to communicate the error to station personnel; provide additional oversight for equipment tagouts affecting required safety systems during the remainder of the refueling outage; and entered the issue into the corrective action program.

This finding is more than minor because it is related to maintenance risk assessment and management. In this instance, Entergy did not implement prescribed significant compensatory measures and effectively manage those measures. Specifically, this finding reflects inadequate risk management that contributed to a short duration loss of shutdown decay heat removal capability resulting from the inadvertent interruption of flow through the operating train of shutdown cooling during cavity flood-up, in preparation for refueling. In accordance with IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Appendix G, "Shutdown Operations Significance Determination Process," the inspectors determined this finding was of very low safety significance (Green). In accordance with IMC 0609, Appendix G, this finding did not require quantification and did not constitute a significant loss of thermal margin, based upon the slow reactor coolant system heat-up rate and minimal time of interruption in shutdown cooling system operation.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not plan and coordinate work activities properly to manage operational impact of work activities. Specifically, the impact on shutdown cooling of deenergizing the 'B' reactor protection system was not recognized or assessed. Additionally, a number of processes and barriers, such as the outage risk assessment and protective equipment program, were not used effectively.

Inspection Report# : [2008004](#) (pdf)

G

Significance: Aug 01, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

RHR Service Water SOV Corrective Actions

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," because Entergy did not implement adequate corrective actions for the residual heat removal (RHR) service water motor bearing cooling water supply solenoid operated valves (SOVs). Specifically, Entergy did not promptly correct a condition adverse to quality associated with trains of RHR service water motor bearing cooling water supply SOVs following a December 30, 2006 failure of the 'B' RHR service water motor bearing cooling water supply valve. This resulted in unplanned unavailability for the 'C' RHR service water motor on May 4, 2007 due to the failure of the 'C' RHR service water motor bearing cooling water supply valve. Entergy entered this lack of taking prompt corrective action into their corrective action program as CR-JAF-2008-02411. In addition, Entergy replaced the 'B' and 'C' RHR service water motor bearing cooling water supply valves.

This finding was more than minor because it impacted the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability, reliability and capability of a system that responds to initiating events to prevent undesirable consequences. The finding was evaluated in accordance with Inspection Manual Chapter (IMC) 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors conducted a Phase 1 Significance Determination Process (SDP) screening and determined that the finding

was of very low safety significance (Green) because the finding was not a design or qualification deficiency, did not represent a loss of system safety function or loss of a single train for greater than its allowed technical specification time, and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy did not thoroughly evaluate a condition adverse to quality such that the resolutions addressed the causes and extent of condition, as necessary. Specifically, Entergy's corrective actions following the 2006 SOV failure did not evaluate the in-service condition of the 'A', 'C', and 'D' RHR service water motor bearing cooling water supply valves.

Inspection Report# : [2008008](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inoperable Control Room Envelope Door

The inspectors identified an NCV of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," because Entergy did not identify and correct a condition adverse to quality related to a control room envelope boundary door. Specifically, on several occasions, Entergy did not identify and implement adequate actions to ensure a control room envelope boundary door, 70DOR-A-300-5, remained latched and able to perform its safety function. Entergy implemented corrective actions which included repair of the latching mechanism to improve the reliability of the door and initiated condition reports CR-JAF-2009-01021 and CR-JAF-2009-01070.

This finding was greater than minor because it affected the barrier integrity attribute of structures, systems, components, and barrier performance under maintaining radiological barrier functionality of the control room and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect operators in the control room from radionuclide releases caused by accidents or events. The finding was evaluated using the SDP Phase I and Phase III because the finding represented a degradation of the barrier function provided for the control room against toxic atmosphere and smoke as well as radiological conditions. The finding was determined to be of very low safety significance, because the amount of time the door was unlatched and ajar was limited to 51 days and, considering the TS allowed outage time of 90 days, the maximum potential time of 51 days represented very low safety significance considering the low probability of a design basis accident during this time period.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution related to the identification component because Entergy personnel did not identify the degraded condition completely and did not recognize the impact that the degraded CRE boundary door had on the control room envelope.

Inspection Report# : [2009002](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: FIN Finding

Inadequate Work Planning for Strain Gauge Resulted in Unplanned Exposure)

A self-revealing finding of very low safety significance was identified because Entergy personnel did not adequately plan and prevent unnecessary exposure consistent with Radiation Work Permit No. 08-0524 controls. Specifically, Entergy staff work planning deficiencies relative to a main steam line strain gauge modification resulted in additional unplanned collective exposure (11.32 person-rem compared to a work activity original estimate of 6.1 person-rem). The job site conditions for installation of the strain gauges were not adequately evaluated by Entergy staff for interferences and the support work involving scaffolding and insulation removal were not adequately planned and coordinated to prevent additional unnecessary exposure. This finding was entered into the corrective action program as CR-JAF-2008-3181.

This finding is greater than minor because it is associated with the program and process attribute of the Occupational Radiation Safety cornerstone and affected the cornerstone objective to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine nuclear reactor operation. The inspectors evaluated the significance of this finding using IMC 0609, Appendix C, AOccupational Radiation Safety Significance Determination Process. The inspectors determined this finding was of very low safety significance (Green) because it involved an actual collective exposure greater than 5 person-rem that was greater than 50% above the estimated or intended exposure.

This finding has a cross-cutting aspect in the area of human performance because Entergy's planned work activities did not adequately incorporate work site interferences or outage work coordination in the work control planning process. (H.3(a))

Inspection Report# : [2009003](#) (pdf)

Public Radiation Safety

Significance: SL-IV Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Make a Written Report of a Non-Conforming Condition Relative to an NRC-Approved Package

A self-revealing NCV of 10 CFR Part 71.95 was identified because Entergy did not provide a written report to the NRC as required by 10 CFR Part 71.95 relative to a non-conforming condition involving the shipment of a NRC-approved package. Entergy was informed that a package it shipped to EnergySolutions™ Barnwell Low Level Radioactive Waste Disposal Facility was found to be in non-conformance with the applicable Certificate of Compliance for the package upon receipt, Entergy did not report the condition to the NRC within 60 days of the occurrence, as required. Failure of Entergy to report the condition, as required by 10 CFR Part 71.95, constitutes a performance deficiency in that the issue is the result of Entergy not meeting a regulatory requirement that was reasonably within Entergy's ability to foresee and correct, and should have been prevented. Entergy entered this issue into the corrective action program as condition report (CR)-2008-02772.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement IV "Transportation," example D4 which states, "a noncompliance with shipping papers, marking, labeling, placarding, packaging or loading not amounting to a Severity Level I, II, or III violation;" the NRC determined this violation is categorized as a SL IV Violation. The Enforcement Policy Supplement I "Reactor Operations" examples D3, D4, and D5 are similar to this issue, in that they discuss examples of failures to make required reports for more than minor events, which are also categorized at Severity Level IV.

This finding has a cross-cutting aspect in the area of problem identification and resolution related - corrective action program, because Entergy performed an insufficient evaluation of a non-conforming condition associated with an NRC-approved package to assure the matter was properly classified, prioritized and evaluated relative to reportability.

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : August 31, 2009

FitzPatrick

3Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

HELB Barrier Doors Left Open and Unattended

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” because Entergy personnel did not maintain an adequate high energy line break (HELB) barrier. Specifically, the inspectors identified that the HELB barrier doors between the turbine building (TB) and ‘A’ emergency diesel generator (EDG) switchgear room were open when required to be closed. The issue was entered into Entergy’s corrective action program (CAP) as condition report (CR)-JAF-2009-02514. Entergy personnel restored the HELB barrier and provided training for operations, maintenance and supervisor personnel on proper work practices.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, during the timeframe that the HELB doors remained open, the reliability of the ‘A’ EDG subsystem to perform its safety function would be challenged during a HELB event. The inspectors evaluated the significance of this finding using IMC 0609.04, “Phase 1 – Initial Screening and Characterization of Findings.” The finding was determined to be of very low safety significance (Green) because it was not a design or qualification deficiency; did not represent a loss of system safety function; and did not screen as potentially risk-significant due to external initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy supervision allowed the HELB barriers to be breached which was inconsistent with the work instructions.

Inspection Report# : [2009004](#) (*pdf*)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

High Energy Line Break Door Missing Lower Support

The inspectors identified an NCV of very low safety significance of 10 CFR 50, Appendix B, Criterion III, “Design Control,” because Entergy personnel did not maintain a high energy line break (HELB) barrier. Specifically, HELB door 76 FDR-DG-272-11, located between the ‘A’ division emergency diesel generator (EDG) switchgear room and the turbine building was in use as a HELB barrier but was not qualified due to a missing support. The issue was entered into Entergy’s corrective program as condition report (CR)-JAF-2009-01895. Corrective actions included installing a lower bottom right side support to enable the door to be qualified for HELB.

This finding is greater than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, Entergy’s engineering calculation previously documented that the door could not be qualified with a missing lower support. The inspectors evaluated the significance of this finding using IMC 0609.04, “Phase 1 – Initial Screening and Characterization of Findings.” The finding was determined to be of very low safety significance (Green) because the finding was a qualification deficiency confirmed not to result in

loss of operability.

The inspectors determined that this finding has a cross-cutting aspect in the area of human performance within the work practices component because Entergy personnel did not ensure that the secondary HELB barrier was qualified as a result of ineffective error prevention techniques. (H.4(a))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Recognize an Adverse HPCI Performance Trend.

A self-revealing NCV of very low safety significance of 10 CFR 50.55a, “Codes and Standards,” was identified because Entergy personnel did not comply with the in-service testing (IST) program requirements contained within the applicable American Society of Mechanical Engineers (ASME) Code for Operation and Maintenance of Nuclear Power Plants. Specifically, Entergy personnel changed the reference value for the stroke time of the 23HOV-1, high pressure coolant injection (HPCI) turbine stop valve, without meeting the required ASME code criteria. Entergy’s corrective actions included replacing the relay valve piston, lapping the relay valve seat, implementing procedure changes requiring additional evaluation within a decreased range of stroke times to open, and performing an extent of condition review of the IST program.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not identify a prior adverse performance trend which resulted in an unplanned extension of the maintenance period for the HPCI system, extending the unavailable period from January 23, 2009 through January 31, 2009. The inspectors determined that the finding was of very low safety significance (Green) using the SDP Phase 3, in accordance with IMC 0609, Appendix A, “Determining the Significance of Reactor Inspection Findings for At-Power Situations.”

The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the resources component because Entergy personnel did not ensure that the procedures and other resources available for inspecting 23HOV-1 and evaluating its performance under the IST program were adequate to assure nuclear safety. (H.2(c))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Balance Chamber Pressure for the HPCI Turbine Stop Valve Was Not Set at a Value to Ensure HPCI Operation

A self-revealing NCV of very low safety significance of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Action,” was identified because Entergy personnel did not identify and correct a condition adverse to quality related to the HPCI system which caused the system to be inoperable between January 30 and April 28, 2009. Specifically, the balance chamber pressure for the HPCI turbine stop valve, 23 HOV-1, was not set at a value to ensure proper operation of the HPCI turbine system and resulted in a HPCI high steam flow isolation during the performance of the surveillance test. Entergy personnel entered the condition into their corrective action program as CR-JAF-2009-01398. Corrective actions included the performance of a root cause analysis, adjustment of the balance chamber pressure to be higher in the acceptance band consistent with operating experience and increasing the frequency of HPCI surveillance testing.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not take adequate corrective action to establish the balance chamber pressure for 23 HOV-1, following an erratic fast opening of the valve on January 30, 2009. The inspectors determined that the finding was of very low safety significance

(Green) using the SDP Phase 3, in accordance with IMC 0609, Appendix A, “Determining the Significance of Reactor Inspection Findings for At-Power Situations.”

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance within the decision-making component because after reviewing the available data and industry operating experience, in January 2009, Entergy personnel incorrectly determined that balance chamber pressure margin was not a contributing cause of the erratic operation of the valve. (H.1(b))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Recognize an Adverse EDG Rotor Insulation Performance Trend.

A self-revealing NCV of very low safety significance of 10 CFR 50, Criterion XVI, “Corrective Action,” was identified because Entergy personnel did not identify and correct a condition adverse to quality related to the emergency diesel generator (EDG) system. Specifically, Entergy personnel did not properly identify and implement adequate actions required by their system monitoring program in response to a degraded generator rotor on the ‘C’ EDG revealed by an adverse performance trend with respect to the insulation resistance and polarization index. Entergy staff initiated CR-JAF-2009-01847 to determine the root causes and recommend further corrective actions. Entergy’s corrective actions included rewinding of the affected pole of the ‘C’ EDG rotor.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not identify an adverse performance trend which resulted in an unplanned extension of the maintenance period for the ‘C’ EDG, extending the unavailable period from May 28 through June 11, 2009. The inspectors evaluated the significance of this finding using IMC 0609.04, “Phase 1 – Initial Screening and Characterization of Findings.” The inspectors determined the finding was of very low safety significance (Green) because the finding was not a qualification or design deficiency, did not represent a loss of a safety function, and did not screen as potentially risk significant due to external initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy personnel did not implement a corrective action program with a low threshold for identifying issues in that the adverse trend in the ‘C’ EDG rotor insulation was not identified. (P.1(a))

Inspection Report# : [2009003](#) (pdf)

Significance: SL-IV Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failed to Submit an LER For a Condition Prohibited by TS Associated With EDG Fuel Oil Supply

The inspectors identified a Severity Level IV, non-cited violation (NCV) because Entergy did not provide a written 60-day report to the NRC as required by 10 CFR 50.73 relative to a condition which was prohibited by Technical Specifications (TS) 3.8.3. Specifically, on several occasions between September 2006 and July 2007 the volume for either the ‘A’ or ‘B’ fuel oil storage tanks (FOST) was such that there was an insufficient quantity of fuel oil to provide a seven day fuel oil supply for the associated emergency diesel generator (EDG) as required per Technical Specifications. Entergy personnel, in determining past reportability, improperly credited the associated fuel oil day tank towards the seven day supply and erroneously concluded on September 18, 2007, that the issue was not reportable. Entergy’s corrective actions included initiation of CR-JAF-2008-04323 and issuance of licensee event report (LER) 2009-001, “Inadequate Engineering Calculation Results in Insufficient Inventory in EDG Fuel Oil Storage Tanks.” In addition, Entergy revised applicable procedures to ensure the fuel oil storage tanks contain adequate fuel oil inventory to remain in compliance with the TS.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using the traditional enforcement process instead of the Significance

Determination Process. Using the Enforcement Policy Supplement I, "Reactor Operations," example D4 which states, "A failure to make a required LER;" the NRC determined this violation is more than minor and categorized as a Severity Level IV violation.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution related to the evaluation component because Entergy personnel did not properly consider the TS basis and, therefore, did not properly evaluate the reportability for the EDG FOSTs.

Inspection Report# : [2009002](#) (*pdf*)

Significance:  Dec 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Quality Standards Not Specified in Design Documents that Resulted in Unsupported HPCI Oil Tubing

An NRC identified NCV of 10 CFR 50 Appendix B, Criterion III, "Design Control," was identified when Entergy did not assure that appropriate quality standards were specified and included in design documents and that deviations from such standards were controlled. Specifically, Entergy did not ensure the oil tubing within the high pressure coolant injection (HPCI) system remained properly supported and routed with an appropriate slope in accordance with design. The issue was entered into Entergy's corrective action program as CR-JAF-2008-04040. Corrective actions included establishing work order 172913 to restore the original configuration properly supporting the HPCI tubing lines.

This finding is more than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, reliability was affected because the unsupported span of tubing was more susceptible to personnel damage and vibration during HPCI operation, both during surveillance testing and also if called upon to perform its safety function. In addition, the tubing was more susceptible to damage and adverse routing changes during maintenance activities. Therefore, over time, the high pressure fittings associated with the lines would be more likely to suffer failures, retain air bubbles within the lines, and/or leak during pump operation affecting the long-term reliability of the system. This was reasonably within Entergy's ability to foresee and prevent because the governing procedures require tube routings, including support locations, be provided during installation of Class I tubing, and a support bracket was available to attach the tubing. The inspectors evaluated the significance of this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green) because the finding represented a design or qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because the design documents, procedures, and work packages used during the maintenance activities in September and October 2008, were not sufficiently complete to ensure design standards were implemented.

Inspection Report# : [2008005](#) (*pdf*)

Significance:  Dec 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Conduct of Relay Test Without Plant Impact Review Resulted in Loss of Emergency Bus and Shutdown Cooling

A self-revealing NCV of 10 CFR Part 50.65 (a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified when Entergy did not manage the increase in risk during the conduct of relay testing associated with emergency buses. The conduct of the relay testing resulted in an unanticipated loss of shutdown cooling (SDC) function. Entergy implemented corrective actions that included communicating the error to personnel to reinforce management expectations for control of protected equipment and providing an additional level of work authorization review.

This finding is more than minor because it is associated with the Mitigating Systems cornerstone and is related to

Entergy's performance in assessing and managing risk. A risk assessment review was not conducted prior to performance of a trip and lockout relay functional test associated with emergency buses. Specifically, this finding reflects inadequate risk management that contributed to a short duration loss of shutdown decay heat removal capability resulting from the inadvertent interruption of flow through the operating train of shutdown cooling with the plant in a cold shutdown condition. This was reasonably within Entergy's ability to foresee and prevent because there were opportunities to recognize and manage the potential risk of losing shutdown cooling and to schedule the maintenance activity at a more appropriate maintenance window or take actions to prevent the loss of shutdown cooling.

In accordance with IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Appendix G, "Shutdown Operations Significance Determination Process," the inspectors determined that this finding was of very low safety significance (Green). The basis for this determination is that in accordance with IMC 0609, Appendix G, Table 1, "Losses of Control," and Checklist 8, "BWR Cold Shutdown or Refueling Operation Time to Boil > 2 Hours: RCS Level <23 feet Above Top of Flange," this finding did not require quantification and did not constitute a significant loss of thermal margin, based upon the slow reactor coolant system heat-up rate and minimal time of interruption in shutdown cooling system operation. The problem was entered into Entergy's corrective action program as CR-JAF-2008-03805.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy did not plan and coordinate work activities properly to manage the operational impact of work activities. Specifically, Entergy did not recognize that the emergency bus 10600 would be de-energized as a result of the trip and lockout relay functional test.

Inspection Report# : [2008005](#) (pdf)

Barrier Integrity

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inoperable Control Room Envelope Door

The inspectors identified an NCV of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," because Entergy did not identify and correct a condition adverse to quality related to a control room envelope boundary door. Specifically, on several occasions, Entergy did not identify and implement adequate actions to ensure a control room envelope boundary door, 70DOR-A-300-5, remained latched and able to perform its safety function. Entergy implemented corrective actions which included repair of the latching mechanism to improve the reliability of the door and initiated condition reports CR-JAF-2009-01021 and CR-JAF-2009-01070.

This finding was greater than minor because it affected the barrier integrity attribute of structures, systems, components, and barrier performance under maintaining radiological barrier functionality of the control room and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect operators in the control room from radionuclide releases caused by accidents or events. The finding was evaluated using the SDP Phase I and Phase III because the finding represented a degradation of the barrier function provided for the control room against toxic atmosphere and smoke as well as radiological conditions. The finding was determined to be of very low safety significance, because the amount of time the door was unlatched and ajar was limited to 51 days and, considering the TS allowed outage time of 90 days, the maximum potential time of 51 days represented very low safety significance considering the low probability of a design basis accident during this time period.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution related to the identification component because Entergy personnel did not identify the degraded condition completely and did not recognize the impact that the degraded CRE boundary door had on the control room envelope.

Inspection Report# : [2009002](#) (pdf)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: FIN Finding

Inadequate Work Planning for Strain Gauge Resulted in Unplanned Exposure)

A self-revealing finding of very low safety significance was identified because Entergy personnel did not adequately plan and prevent unnecessary exposure consistent with Radiation Work Permit No. 08-0524 controls. Specifically, Entergy staff work planning deficiencies relative to a main steam line strain gauge modification resulted in additional unplanned collective exposure (11.32 person-rem compared to a work activity original estimate of 6.1 person-rem). The job site conditions for installation of the strain gauges were not adequately evaluated by Entergy staff for interferences and the support work involving scaffolding and insulation removal were not adequately planned and coordinated to prevent additional unnecessary exposure. This finding was entered into the corrective action program as CR-JAF-2008-3181.

This finding is greater than minor because it is associated with the program and process attribute of the Occupational Radiation Safety cornerstone and affected the cornerstone objective to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine nuclear reactor operation. The inspectors evaluated the significance of this finding using IMC 0609, Appendix C, AOccupational Radiation Safety Significance Determination Process.@ The inspectors determined this finding was of very low safety significance (Green) because it involved an actual collective exposure greater than 5 person-rem that was greater than 50% above the estimated or intended exposure.

This finding has a cross-cutting aspect in the area of human performance because Entergy's planned work activities did not adequately incorporate work site interferences or outage work coordination in the work control planning process. (H.3(a))

Inspection Report# : [2009003](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : December 10, 2009

FitzPatrick

4Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Emergency Lighting Not Monitored in Accordance with 10 CFR Part 50.65 (a)(1)

The inspectors identified an NCV of 10 CFR Part 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy staff did not demonstrate that the performance of the emergency lighting system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1). Specifically, the inspectors identified that a second emergency light failure had not been correctly classified as a functional failure as documented in condition report (CR)-JAF-2009-02768, initiated on August 12, 2009. The issue was entered into Entergy's corrective action program (CAP) as CR-JAF-2009-02999 and Entergy classified the emergency lighting system (a)(1) due to this repeat failure. Additionally, the emergency lighting battery preventive maintenance replacement period was reduced from 24 months to 18 months due to an excessive number of emergency lighting battery failures that occurred between 18 and 24 months.

This finding is more than minor because it affected the external factors attribute (fire) of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, plant operators rely on emergency lighting to provide lighting to complete actions described in emergency operating procedures in case of a partial or complete loss of normal plant lighting. Additionally, Appendix R emergency lighting supports time critical post-fire safe shutdown manual actions and the availability of the emergency lighting battery system was affected. The emergency lighting system had not been maintained sufficiently to provide for reliable operation of the equipment.

The inspectors determined the significance of the finding using IMC 0609, Appendix F, "Fire Protection Significance Determination Process." This finding affected post-fire safe shutdown. The finding was determined to be of very low safety significance (Green) because the inspectors assigned a low degradation rating in phase 1 of the SDP. The inspectors assigned a low degradation rating because the issue did not have a significant impact on safe shutdown operations: operators, carry flashlights, the three emergency portable lighting units located in the control room were available, and there were not specific plant areas that had widespread emergency lighting outages at any one time.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution within the CAP component because Entergy personnel did not address an adverse trend in the emergency lighting battery system in a timely manner. (P.1(d))

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Standby Liquid Control Not Monitored in Accordance with 10 CFR Part 50.65 (a)(1)

The inspectors identified an NCV of 10 CFR Part 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy staff did not demonstrate that the performance of the standby

liquid control (SLC) system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1). Entergy initiated CR-JAF-2009-03994 and CR-JAF-2009-04017 to address the issues and classified the SLC system as (a)(1) due to the repetitive maintenance preventable failures and the incomplete corrective actions related to increasing the PM frequency from every two months to once a month.

The inspectors determined the finding is more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, plant operators rely on the SLC tank level indication in the control room for performing actions required by emergency operating procedures and the availability of this indication was affected.

The inspectors determined the significance of the finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding was determined to be of very low safety significance (Green) because it was not a design or qualification deficiency; did not represent a loss of system safety function; and did not screen as potentially risk-significant due to external initiating events. Specifically, the loss of control indication did not render the SLC system incapable of injecting borated water into the reactor coolant system, and operators remained capable of measuring the level of the SLC tank locally using manual dipping.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution within the CAP component because Entergy personnel did not address an adverse trend in the SLC tank level indication in a timely manner. (P.1(d))

Inspection Report# : [2009005](#) (pdf)

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

HELB Barrier Doors Left Open and Unattended

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because Entergy personnel did not maintain an adequate high energy line break (HELB) barrier. Specifically, the inspectors identified that the HELB barrier doors between the turbine building (TB) and 'A' emergency diesel generator (EDG) switchgear room were open when required to be closed. The issue was entered into Entergy's corrective action program (CAP) as condition report (CR)-JAF-2009-02514. Entergy personnel restored the HELB barrier and provided training for operations, maintenance and supervisor personnel on proper work practices.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, during the timeframe that the HELB doors remained open, the reliability of the 'A' EDG subsystem to perform its safety function would be challenged during a HELB event. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding was determined to be of very low safety significance (Green) because it was not a design or qualification deficiency; did not represent a loss of system safety function; and did not screen as potentially risk-significant due to external initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy supervision allowed the HELB barriers to be breached which was inconsistent with the work instructions.

Inspection Report# : [2009004](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

High Energy Line Break Door Missing Lower Support

The inspectors identified an NCV of very low safety significance of 10 CFR 50, Appendix B, Criterion III, "Design

Control,” because Entergy personnel did not maintain a high energy line break (HELB) barrier. Specifically, HELB door 76 FDR-DG-272-11, located between the ‘A’ division emergency diesel generator (EDG) switchgear room and the turbine building was in use as a HELB barrier but was not qualified due to a missing support. The issue was entered into Entergy’s corrective program as condition report (CR)-JAF-2009-01895. Corrective actions included installing a lower bottom right side support to enable the door to be qualified for HELB.

This finding is greater than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, Entergy’s engineering calculation previously documented that the door could not be qualified with a missing lower support. The inspectors evaluated the significance of this finding using IMC 0609.04, “Phase 1 – Initial Screening and Characterization of Findings.” The finding was determined to be of very low safety significance (Green) because the finding was a qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding has a cross-cutting aspect in the area of human performance within the work practices component because Entergy personnel did not ensure that the secondary HELB barrier was qualified as a result of ineffective error prevention techniques. (H.4(a))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Recognize an Adverse HPCI Performance Trend.

A self-revealing NCV of very low safety significance of 10 CFR 50.55a, “Codes and Standards,” was identified because Entergy personnel did not comply with the in-service testing (IST) program requirements contained within the applicable American Society of Mechanical Engineers (ASME) Code for Operation and Maintenance of Nuclear Power Plants. Specifically, Entergy personnel changed the reference value for the stroke time of the 23HOV-1, high pressure coolant injection (HPCI) turbine stop valve, without meeting the required ASME code criteria. Entergy’s corrective actions included replacing the relay valve piston, lapping the relay valve seat, implementing procedure changes requiring additional evaluation within a decreased range of stroke times to open, and performing an extent of condition review of the IST program.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not identify a prior adverse performance trend which resulted in an unplanned extension of the maintenance period for the HPCI system, extending the unavailable period from January 23, 2009 through January 31, 2009. The inspectors determined that the finding was of very low safety significance (Green) using the SDP Phase 3, in accordance with IMC 0609, Appendix A, “Determining the Significance of Reactor Inspection Findings for At-Power Situations.”

The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the resources component because Entergy personnel did not ensure that the procedures and other resources available for inspecting 23HOV-1 and evaluating its performance under the IST program were adequate to assure nuclear safety. (H.2(c))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Balance Chamber Pressure for the HPCI Turbine Stop Valve Was Not Set at a Value to Ensure HPCI Operation

A self-revealing NCV of very low safety significance of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Action,” was identified because Entergy personnel did not identify and correct a condition adverse to quality related to the HPCI system which caused the system to be inoperable between January 30 and April 28, 2009. Specifically, the

balance chamber pressure for the HPCI turbine stop valve, 23 HOV-1, was not set at a value to ensure proper operation of the HPCI turbine system and resulted in a HPCI high steam flow isolation during the performance of the surveillance test. Entergy personnel entered the condition into their corrective action program as CR-JAF-2009-01398. Corrective actions included the performance of a root cause analysis, adjustment of the balance chamber pressure to be higher in the acceptance band consistent with operating experience and increasing the frequency of HPCI surveillance testing.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not take adequate corrective action to establish the balance chamber pressure for 23 HOV-1, following an erratic fast opening of the valve on January 30, 2009. The inspectors determined that the finding was of very low safety significance (Green) using the SDP Phase 3, in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations."

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance within the decision-making component because after reviewing the available data and industry operating experience, in January 2009, Entergy personnel incorrectly determined that balance chamber pressure margin was not a contributing cause of the erratic operation of the valve. (H.1(b))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Recognize an Adverse EDG Rotor Insulation Performance Trend.

A self-revealing NCV of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," was identified because Entergy personnel did not identify and correct a condition adverse to quality related to the emergency diesel generator (EDG) system. Specifically, Entergy personnel did not properly identify and implement adequate actions required by their system monitoring program in response to a degraded generator rotor on the 'C' EDG revealed by an adverse performance trend with respect to the insulation resistance and polarization index. Entergy staff initiated CR-JAF-2009-01847 to determine the root causes and recommend further corrective actions. Entergy's corrective actions included rewinding of the affected pole of the 'C' EDG rotor.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not identify an adverse performance trend which resulted in an unplanned extension of the maintenance period for the 'C' EDG, extending the unavailable period from May 28 through June 11, 2009. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined the finding was of very low safety significance (Green) because the finding was not a qualification or design deficiency, did not represent a loss of a safety function, and did not screen as potentially risk significant due to external initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy personnel did not implement a corrective action program with a low threshold for identifying issues in that the adverse trend in the 'C' EDG rotor insulation was not identified. (P.1(a))

Inspection Report# : [2009003](#) (pdf)

Significance: SL-IV Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failed to Submit an LER For a Condition Prohibited by TS Associated With EDG Fuel Oil Supply

The inspectors identified a Severity Level IV, non-cited violation (NCV) because Entergy did not provide a written 60-day report to the NRC as required by 10 CFR 50.73 relative to a condition which was prohibited by Technical

Specifications (TS) 3.8.3. Specifically, on several occasions between September 2006 and July 2007 the volume for either the 'A' or 'B' fuel oil storage tanks (FOST) was such that there was an insufficient quantity of fuel oil to provide a seven day fuel oil supply for the associated emergency diesel generator (EDG) as required per Technical Specifications. Entergy personnel, in determining past reportability, improperly credited the associated fuel oil day tank towards the seven day supply and erroneously concluded on September 18, 2007, that the issue was not reportable. Entergy's corrective actions included initiation of CR-JAF-2008-04323 and issuance of licensee event report (LER) 2009-001, "Inadequate Engineering Calculation Results in Insufficient Inventory in EDG Fuel Oil Storage Tanks." In addition, Entergy revised applicable procedures to ensure the fuel oil storage tanks contain adequate fuel oil inventory to remain in compliance with the TS.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using the traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement I, "Reactor Operations," example D4 which states, "A failure to make a required LER;" the NRC determined this violation is more than minor and categorized as a Severity Level IV violation.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution related to the evaluation component because Entergy personnel did not properly consider the TS basis and, therefore, did not properly evaluate the reportability for the EDG FOSTs.

Inspection Report# : [2009002](#) (pdf)

Barrier Integrity

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inoperable Control Room Envelope Door

The inspectors identified an NCV of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," because Entergy did not identify and correct a condition adverse to quality related to a control room envelope boundary door. Specifically, on several occasions, Entergy did not identify and implement adequate actions to ensure a control room envelope boundary door, 70DOR-A-300-5, remained latched and able to perform its safety function. Entergy implemented corrective actions which included repair of the latching mechanism to improve the reliability of the door and initiated condition reports CR-JAF-2009-01021 and CR-JAF-2009-01070.

This finding was greater than minor because it affected the barrier integrity attribute of structures, systems, components, and barrier performance under maintaining radiological barrier functionality of the control room and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect operators in the control room from radionuclide releases caused by accidents or events. The finding was evaluated using the SDP Phase I and Phase III because the finding represented a degradation of the barrier function provided for the control room against toxic atmosphere and smoke as well as radiological conditions. The finding was determined to be of very low safety significance, because the amount of time the door was unlatched and ajar was limited to 51 days and, considering the TS allowed outage time of 90 days, the maximum potential time of 51 days represented very low safety significance considering the low probability of a design basis accident during this time period.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution related to the identification component because Entergy personnel did not identify the degraded condition completely and did not recognize the impact that the degraded CRE boundary door had on the control room envelope.

Inspection Report# : [2009002](#) (pdf)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: FIN Finding

Inadequate Work Planning for Strain Gauge Resulted in Unplanned Exposure)

A self-revealing finding of very low safety significance was identified because Entergy personnel did not adequately plan and prevent unnecessary exposure consistent with Radiation Work Permit No. 08-0524 controls. Specifically, Entergy staff work planning deficiencies relative to a main steam line strain gauge modification resulted in additional unplanned collective exposure (11.32 person-rem compared to a work activity original estimate of 6.1 person-rem). The job site conditions for installation of the strain gauges were not adequately evaluated by Entergy staff for interferences and the support work involving scaffolding and insulation removal were not adequately planned and coordinated to prevent additional unnecessary exposure. This finding was entered into the corrective action program as CR-JAF-2008-3181.

This finding is greater than minor because it is associated with the program and process attribute of the Occupational Radiation Safety cornerstone and affected the cornerstone objective to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine nuclear reactor operation. The inspectors evaluated the significance of this finding using IMC 0609, Appendix C, AOccupational Radiation Safety Significance Determination Process.@ The inspectors determined this finding was of very low safety significance (Green) because it involved an actual collective exposure greater than 5 person-rem that was greater than 50% above the estimated or intended exposure.

This finding has a cross-cutting aspect in the area of human performance because Entergy's planned work activities did not adequately incorporate work site interferences or outage work coordination in the work control planning process. (H.3(a))

Inspection Report# : [2009003](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : March 01, 2010

FitzPatrick

1Q/2010 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: SL-IV Mar 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER for a Condition Prohibited by TS Associated with HPCI

The inspectors identified a Severity Level IV, non-cited violation (NCV) because Entergy did not provide a written report to the NRC within 60 days after discovery of the event as required by 10 CFR 50.73, "Licensee Event Report (LER) System," for a condition which was prohibited by Technical Specification (TS) 3.5.1, "Emergency Core Cooling Systems - Operating."

In January, 2009, the high pressure coolant injection (HPCI) system did not pass post-maintenance testing, as a result of the failure of the HPCI system turbine stop valve 23HOV-1, to stroke open within the required time. Entergy personnel documented the condition in CR-JAF-2009-0350. The inservice test (IST) opening time for 23HOV-1 had previously exceeded the correct acceptance criteria which should have resulted in declaring the HPCI system inoperable. The inspectors determined that this condition met the criteria for reporting under 10 CFR 50.73 (a)(2)(i) (B) in that the condition was not allowed by the plant's TSs. Entergy's corrective actions included initiating CR-JAF-2009-03964, submitting LER 05000333/2009008-00 on January 11, 2010, and providing additional guidance for their staff on licensee event reporting requirements.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using the traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement I, "Reactor Operations," example D4 which states, "A failure to make a required LER;" the NRC determined that this violation could potentially impact the regulatory process and is more than minor and categorized as a Severity Level IV violation.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution within the corrective action program component because Entergy personnel did not properly evaluate the condition reporting criteria.

Inspection Report# : [2010002](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Emergency Lighting Not Monitored in Accordance with 10 CFR Part 50.65 (a)(1)

The inspectors identified an NCV of 10 CFR Part 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy staff did not demonstrate that the performance of the emergency lighting system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1). Specifically, the inspectors identified that a second emergency light failure had not been correctly classified as a functional failure as documented in condition report (CR)-JAF-2009-02768, initiated on August 12, 2009. The issue was entered into Entergy's corrective action program (CAP) as CR-JAF-2009-02999 and Entergy classified the emergency lighting system (a)(1) due to this repeat failure. Additionally, the emergency lighting battery preventive maintenance replacement period was reduced from 24 months to 18 months due to an excessive number of emergency lighting battery failures that occurred between 18 and 24 months.

This finding is more than minor because it affected the external factors attribute (fire) of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, plant operators rely on emergency lighting to provide lighting to complete actions described in emergency operating procedures in case of a partial or complete loss of normal plant lighting. Additionally, Appendix R emergency lighting supports time critical post-fire safe shutdown manual actions and the availability of the emergency lighting battery system was affected. The emergency lighting system had not been maintained sufficiently to provide for reliable operation of the equipment.

The inspectors determined the significance of the finding using IMC 0609, Appendix F, “Fire Protection Significance Determination Process.” This finding affected post-fire safe shutdown. The finding was determined to be of very low safety significance (Green) because the inspectors assigned a low degradation rating in phase 1 of the SDP. The inspectors assigned a low degradation rating because the issue did not have a significant impact on safe shutdown operations: operators, carry flashlights, the three emergency portable lighting units located in the control room were available, and there were not specific plant areas that had widespread emergency lighting outages at any one time.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution within the CAP component because Entergy personnel did not address an adverse trend in the emergency lighting battery system in a timely manner. (P.1(d))

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Standby Liquid Control Not Monitored in Accordance with 10 CFR Part 50.65 (a)(1)

The inspectors identified an NCV of 10 CFR Part 50.65, “Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants,” because Entergy staff did not demonstrate that the performance of the standby liquid control (SLC) system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1). Entergy initiated CR-JAF-2009-03994 and CR-JAF-2009-04017 to address the issues and classified the SLC system as (a)(1) due to the repetitive maintenance preventable failures and the incomplete corrective actions related to increasing the PM frequency from every two months to once a month.

The inspectors determined the finding is more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, plant operators rely on the SLC tank level indication in the control room for performing actions required by emergency operating procedures and the availability of this indication was affected.

The inspectors determined the significance of the finding using IMC 0609.04, “Phase 1 – Initial Screening and Characterization of Findings.” The finding was determined to be of very low safety significance (Green) because it was not a design or qualification deficiency; did not represent a loss of system safety function; and did not screen as potentially risk-significant due to external initiating events. Specifically, the loss of control indication did not render the SLC system incapable of injecting borated water into the reactor coolant system, and operators remained capable of measuring the level of the SLC tank locally using manual dipping.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution within the CAP component because Entergy personnel did not address an adverse trend in the SLC tank level indication in a timely manner. (P.1(d))

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

HELB Barrier Doors Left Open and Unattended

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because Entergy personnel did not maintain an adequate high energy line break (HELB) barrier. Specifically, the inspectors identified that the HELB barrier doors between the turbine building (TB) and 'A' emergency diesel generator (EDG) switchgear room were open when required to be closed. The issue was entered into Entergy's corrective action program (CAP) as condition report (CR)-JAF-2009-02514. Entergy personnel restored the HELB barrier and provided training for operations, maintenance and supervisor personnel on proper work practices.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, during the timeframe that the HELB doors remained open, the reliability of the 'A' EDG subsystem to perform its safety function would be challenged during a HELB event. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding was determined to be of very low safety significance (Green) because it was not a design or qualification deficiency; did not represent a loss of system safety function; and did not screen as potentially risk-significant due to external initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy supervision allowed the HELB barriers to be breached which was inconsistent with the work instructions.

Inspection Report# : [2009004](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

High Energy Line Break Door Missing Lower Support

The inspectors identified an NCV of very low safety significance of 10 CFR 50, Appendix B, Criterion III, "Design Control," because Entergy personnel did not maintain a high energy line break (HELB) barrier. Specifically, HELB door 76 FDR-DG-272-11, located between the 'A' division emergency diesel generator (EDG) switchgear room and the turbine building was in use as a HELB barrier but was not qualified due to a missing support. The issue was entered into Entergy's corrective program as condition report (CR)-JAF-2009-01895. Corrective actions included installing a lower bottom right side support to enable the door to be qualified for HELB.

This finding is greater than minor because it is associated with the design control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, Entergy's engineering calculation previously documented that the door could not be qualified with a missing lower support. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding was determined to be of very low safety significance (Green) because the finding was a qualification deficiency confirmed not to result in loss of operability.

The inspectors determined that this finding has a cross-cutting aspect in the area of human performance within the work practices component because Entergy personnel did not ensure that the secondary HELB barrier was qualified as a result of ineffective error prevention techniques. (H.4(a))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Recognize an Adverse HPCI Performance Trend.

A self-revealing NCV of very low safety significance of 10 CFR 50.55a, "Codes and Standards," was identified because Entergy personnel did not comply with the in-service testing (IST) program requirements contained within the applicable American Society of Mechanical Engineers (ASME) Code for Operation and Maintenance of Nuclear

Power Plants. Specifically, Entergy personnel changed the reference value for the stroke time of the 23HOV-1, high pressure coolant injection (HPCI) turbine stop valve, without meeting the required ASME code criteria. Entergy's corrective actions included replacing the relay valve piston, lapping the relay valve seat, implementing procedure changes requiring additional evaluation within a decreased range of stroke times to open, and performing an extent of condition review of the IST program.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not identify a prior adverse performance trend which resulted in an unplanned extension of the maintenance period for the HPCI system, extending the unavailable period from January 23, 2009 through January 31, 2009. The inspectors determined that the finding was of very low safety significance (Green) using the SDP Phase 3, in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations."

The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the resources component because Entergy personnel did not ensure that the procedures and other resources available for inspecting 23HOV-1 and evaluating its performance under the IST program were adequate to assure nuclear safety. (H.2(c))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Balance Chamber Pressure for the HPCI Turbine Stop Valve Was Not Set at a Value to Ensure HPCI Operation

A self-revealing NCV of very low safety significance of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified because Entergy personnel did not identify and correct a condition adverse to quality related to the HPCI system which caused the system to be inoperable between January 30 and April 28, 2009. Specifically, the balance chamber pressure for the HPCI turbine stop valve, 23 HOV-1, was not set at a value to ensure proper operation of the HPCI turbine system and resulted in a HPCI high steam flow isolation during the performance of the surveillance test. Entergy personnel entered the condition into their corrective action program as CR-JAF-2009-01398. Corrective actions included the performance of a root cause analysis, adjustment of the balance chamber pressure to be higher in the acceptance band consistent with operating experience and increasing the frequency of HPCI surveillance testing.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not take adequate corrective action to establish the balance chamber pressure for 23 HOV-1, following an erratic fast opening of the valve on January 30, 2009. The inspectors determined that the finding was of very low safety significance (Green) using the SDP Phase 3, in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations."

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance within the decision-making component because after reviewing the available data and industry operating experience, in January 2009, Entergy personnel incorrectly determined that balance chamber pressure margin was not a contributing cause of the erratic operation of the valve. (H.1(b))

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Recognize an Adverse EDG Rotor Insulation Performance Trend.

A self-revealing NCV of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," was

identified because Entergy personnel did not identify and correct a condition adverse to quality related to the emergency diesel generator (EDG) system. Specifically, Entergy personnel did not properly identify and implement adequate actions required by their system monitoring program in response to a degraded generator rotor on the 'C' EDG revealed by an adverse performance trend with respect to the insulation resistance and polarization index. Entergy staff initiated CR-JAF-2009-01847 to determine the root causes and recommend further corrective actions. Entergy's corrective actions included rewinding of the affected pole of the 'C' EDG rotor.

This finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, Entergy personnel did not identify an adverse performance trend which resulted in an unplanned extension of the maintenance period for the 'C' EDG, extending the unavailable period from May 28 through June 11, 2009. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined the finding was of very low safety significance (Green) because the finding was not a qualification or design deficiency, did not represent a loss of a safety function, and did not screen as potentially risk significant due to external initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because Entergy personnel did not implement a corrective action program with a low threshold for identifying issues in that the adverse trend in the 'C' EDG rotor insulation was not identified. (P.1(a))

Inspection Report# : [2009003](#) (pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: FIN Finding

Inadequate Work Planning for Strain Gauge Resulted in Unplanned Exposure)

A self-revealing finding of very low safety significance was identified because Entergy personnel did not adequately plan and prevent unnecessary exposure consistent with Radiation Work Permit No. 08-0524 controls. Specifically, Entergy staff work planning deficiencies relative to a main steam line strain gauge modification resulted in additional unplanned collective exposure (11.32 person-rem compared to a work activity original estimate of 6.1 person-rem). The job site conditions for installation of the strain gauges were not adequately evaluated by Entergy staff for interferences and the support work involving scaffolding and insulation removal were not adequately planned and coordinated to prevent additional unnecessary exposure. This finding was entered into the corrective action program as CR-JAF-2008-3181.

This finding is greater than minor because it is associated with the program and process attribute of the Occupational Radiation Safety cornerstone and affected the cornerstone objective to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine nuclear reactor operation. The inspectors evaluated the significance of this finding using IMC 0609, Appendix C, AOccupational Radiation Safety Significance Determination Process.@ The inspectors determined this finding was of very low safety significance (Green) because it involved an actual collective exposure greater than 5 person-rem that was greater than 50% above the estimated or intended exposure.

This finding has a cross-cutting aspect in the area of human performance because Entergy's planned work activities did not adequately incorporate work site interferences or outage work coordination in the work control planning process. (H.3(a))

Inspection Report# : [2009003](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : May 26, 2010

FitzPatrick

2Q/2010 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Fire Barrier Penetrations Not Maintained as Qualified Three Hour Fire Barriers

A self-revealing non-cited violation (NCV) of very low safety significance of license condition 2.C(3), "Fire Protection," was identified because Entergy personnel did not implement and maintain in effect all provisions of the approved fire protection program when multiple electrical and mechanical three hour fire barrier penetrations were not qualified to perform their required three hour fire barrier function. Entergy initiated condition report (CR)-JAF-2010-01417, CR-JAF-2010-01432, CR-JAF-2010-01438, and CR-JAF-2010-01441 to address the issues, implemented fire watches as compensatory measures, poured new qualified seals, and revised maintenance procedures for installing penetration seals to explicitly describe the need to pre-mix the powder component with the liquid elastomer.

This finding is more than minor because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, multiple fire barrier penetrations were not qualified to perform their required three hour fire barrier function and provided a barrier to fire that was less than that provided by the properly installed and qualified fire barriers. The inspectors determined the significance of the finding using Inspection Manual Chapter (IMC) 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance (Green) because the deficiency represented a low degradation rating, since the non-qualified seals consisted of base components which had been qualified as three hour fire barriers at other nuclear facilities. The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the work practices component because Entergy personnel proceeded in the face of unexpected circumstances when the packaging for the kits changed and when kits were issued without a powder component.

Inspection Report# : [2010003](#) (*pdf*)

Significance: SL-IV Mar 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER for a Condition Prohibited by TS Associated with HPCI

The inspectors identified a Severity Level IV, non-cited violation (NCV) because Entergy did not provide a written report to the NRC within 60 days after discovery of the event as required by 10 CFR 50.73, "Licensee Event Report (LER) System," for a condition which was prohibited by Technical Specification (TS) 3.5.1, "Emergency Core Cooling Systems - Operating."

In January, 2009, the high pressure coolant injection (HPCI) system did not pass post-maintenance testing, as a result of the failure of the HPCI system turbine stop valve 23HOV-1, to stroke open within the required time. Entergy personnel documented the condition in CR-JAF-2009-0350. The inservice test (IST) opening time for 23HOV-1 had previously exceeded the correct acceptance criteria which should have resulted in declaring the HPCI system inoperable. The inspectors determined that this condition met the criteria for reporting under 10 CFR 50.73 (a)(2)(i) (B) in that the condition was not allowed by the plant's TSs. Entergy's corrective actions included initiating CR-JAF-2009-03964, submitting LER 05000333/2009008-00 on January 11, 2010, and providing additional guidance for their

staff on licensee event reporting requirements.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using the traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement I, "Reactor Operations," example D4 which states, "A failure to make a required LER," the NRC determined that this violation could potentially impact the regulatory process and is more than minor and categorized as a Severity Level IV violation.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution within the corrective action program component because Entergy personnel did not properly evaluate the condition reporting criteria.

Inspection Report# : [2010002](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Emergency Lighting Not Monitored in Accordance with 10 CFR Part 50.65 (a)(1)

The inspectors identified an NCV of 10 CFR Part 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy staff did not demonstrate that the performance of the emergency lighting system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1). Specifically, the inspectors identified that a second emergency light failure had not been correctly classified as a functional failure as documented in condition report (CR)-JAF-2009-02768, initiated on August 12, 2009. The issue was entered into Entergy's corrective action program (CAP) as CR-JAF-2009-02999 and Entergy classified the emergency lighting system (a)(1) due to this repeat failure. Additionally, the emergency lighting battery preventive maintenance replacement period was reduced from 24 months to 18 months due to an excessive number of emergency lighting battery failures that occurred between 18 and 24 months.

This finding is more than minor because it affected the external factors attribute (fire) of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, plant operators rely on emergency lighting to provide lighting to complete actions described in emergency operating procedures in case of a partial or complete loss of normal plant lighting. Additionally, Appendix R emergency lighting supports time critical post-fire safe shutdown manual actions and the availability of the emergency lighting battery system was affected. The emergency lighting system had not been maintained sufficiently to provide for reliable operation of the equipment.

The inspectors determined the significance of the finding using IMC 0609, Appendix F, "Fire Protection Significance Determination Process." This finding affected post-fire safe shutdown. The finding was determined to be of very low safety significance (Green) because the inspectors assigned a low degradation rating in phase 1 of the SDP. The inspectors assigned a low degradation rating because the issue did not have a significant impact on safe shutdown operations: operators, carry flashlights, the three emergency portable lighting units located in the control room were available, and there were not specific plant areas that had widespread emergency lighting outages at any one time.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution within the CAP component because Entergy personnel did not address an adverse trend in the emergency lighting battery system in a timely manner. (P.1(d))

Inspection Report# : [2009005](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Standby Liquid Control Not Monitored in Accordance with 10 CFR Part 50.65 (a)(1)

The inspectors identified an NCV of 10 CFR Part 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy staff did not demonstrate that the performance of the standby

liquid control (SLC) system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1). Entergy initiated CR-JAF-2009-03994 and CR-JAF-2009-04017 to address the issues and classified the SLC system as (a)(1) due to the repetitive maintenance preventable failures and the incomplete corrective actions related to increasing the PM frequency from every two months to once a month.

The inspectors determined the finding is more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, plant operators rely on the SLC tank level indication in the control room for performing actions required by emergency operating procedures and the availability of this indication was affected.

The inspectors determined the significance of the finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding was determined to be of very low safety significance (Green) because it was not a design or qualification deficiency; did not represent a loss of system safety function; and did not screen as potentially risk-significant due to external initiating events. Specifically, the loss of control indication did not render the SLC system incapable of injecting borated water into the reactor coolant system, and operators remained capable of measuring the level of the SLC tank locally using manual dipping.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution within the CAP component because Entergy personnel did not address an adverse trend in the SLC tank level indication in a timely manner. (P.1(d))

Inspection Report# : [2009005](#) (pdf)

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

HELB Barrier Doors Left Open and Unattended

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because Entergy personnel did not maintain an adequate high energy line break (HELB) barrier. Specifically, the inspectors identified that the HELB barrier doors between the turbine building (TB) and 'A' emergency diesel generator (EDG) switchgear room were open when required to be closed. The issue was entered into Entergy's corrective action program (CAP) as condition report (CR)-JAF-2009-02514. Entergy personnel restored the HELB barrier and provided training for operations, maintenance and supervisor personnel on proper work practices.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, during the timeframe that the HELB doors remained open, the reliability of the 'A' EDG subsystem to perform its safety function would be challenged during a HELB event. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding was determined to be of very low safety significance (Green) because it was not a design or qualification deficiency; did not represent a loss of system safety function; and did not screen as potentially risk-significant due to external initiating events.

The inspectors determined that this finding had a cross-cutting aspect in the area of human performance because Entergy supervision allowed the HELB barriers to be breached which was inconsistent with the work instructions.

Inspection Report# : [2009004](#) (pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : September 02, 2010

FitzPatrick

3Q/2010 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Appendix R Fire Door Blocked Open Without Establishing Required Measures

The inspectors identified a non-cited violation (NCV) of very low safety significance of license condition 2.C(3), "Fire Protection," because Entergy personnel blocked a fire door in the open position, defeating its required three hour fire barrier function, without establishing the required compensatory measures. Entergy entered this issue into their CAP as CR-JAF-2010-04825, issued a night order emphasizing the requirements associated with propping open fire doors, provided coaching, and submitted a procedure change request to further clarify procedural applicability requirements.

This finding is more than minor because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the fire door being affixed open without the knowledge of the control room personnel and other operators and without an assigned fire watch resulted in a barrier to fire propagation that was less robust than required by the approved fire protection program. The inspectors determined the significance of the finding using IMC 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance (Green) because the deficiency represented a low degradation rating. Specifically, the individuals involved were members of the fire brigade, qualified in fire watch duties, and only blocked the door open during resin container transfers. The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the work practices component because Entergy did not effectively communicate expectations to personnel regarding the applicable procedures and personnel did not follow the procedures (H.4(b)).

Inspection Report# : [2010004](#) (*pdf*)

Significance:  Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Use Largest Load During EDG Reject Surveillance Test

The team identified a finding involving a non-cited violation of James A. FitzPatrick Technical Specification (TS) Surveillance Requirement (SR) 3.8.1.8 because Entergy did not adequately perform the largest post-accident load rejection test as required by the SR. Specifically, Entergy's surveillance test that implemented this SR rejected a load of about 1000 brake horse power (BHP) and the largest post-accident load calculated by Entergy was 1270 BHP. Entergy entered this issue into their corrective action program to evaluate operability of each emergency diesel generator (EDG) subsystem and to correct the surveillance test for rejection of the largest postaccident load. The team reviewed Entergy's operability determination and concluded it appropriately determined the EDG subsystems were operable but non-conforming to SR 3.8.1.8.

This finding is more than minor because it is associated with the Procedure Quality Attribute (maintenance and testing) of the Mitigating Systems Cornerstone and affected

the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating event to prevent undesirable consequences. The team performed a Phase 1 SDP screening, in accordance with NRC IMC 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," and determined the finding was of very low safety Significance (Green) because it was a qualification deficiency confirmed not to result in loss of operability. The team did not identify a cross-cutting aspect associated with the finding. (1 R21.2.1.1)

Inspection Report# : [2010006](#) (pdf)

Significance: **G** Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Calculations for Offsite Power Availability

The team identified a finding involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," in that Entergy did not verify the adequacy of design with respect to establishing the basis for the offsite power minimum voltage and the degraded voltage relay reset setpoint. Specifically, Entergy failed to adequately evaluate the results of load flow studies that determined safety bus voltage would be below the relay reset value following some design basis events. The team concluded that this could result in separation of the vital busses from the offsite power supply during some design basis events. Entergy entered this issue in the corrective action program to verify offsite power was operable, and instructed the offsite grid operator to raise the minimum grid voltage limit and revise the post accident grid loading profile. The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of very low safety significance (Green) because it was a design deficiency confirmed not to result in a loss of the offsite power supply operability or functionality.

This finding had a cross-cutting aspect in the area of Human Performance Resources because the licensee did not ensure that personnel, equipment, procedures, and other resources are available to ensure complete, accurate and up-to-date design documentation. Specifically, the acceptance criteria in the recently completed calculations that evaluated the offsite power voltage limit was not correct which resulted in an incorrect evaluation of the results of the calculation. (IMC 0310, Section H.2(c)) (1 R21.2.1.2)

Inspection Report# : [2010006](#) (pdf)

Significance: **G** Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Action on RHRSW Strainer Housing Wall Degradation

The team identified a finding involving a non-cited violation of 10 CFR 50, Appendix 8, Criterion XVI, "Corrective Actions," for failure to identify and correct a condition adverse to quality. Specifically, Entergy did not take corrective actions to evaluate the rate of identified degradation on the 1 OS-58 1 residual heat removal service water (RHRSW) strainer casing. This resulted in a through wall leak in the strainer which was identified by the team. The team's review found that in 2006 Entergy had conducted ultrasonic test (UT) measurements of the strainer and determined that degradation was occurring. Corrective actions for the deficiency required that a UT examination be performed to monitor for further degradation but it was not performed. In response, Entergy entered the issue into the corrective action program, and conducted an UT examination at the leak location to determine the size and extent of the defect which determined that strainer's structural integrity was maintained.

The finding is more than minor because it is associated with the equipment performance

attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of very low safety significance (Green) because the finding was determined to be a qualification deficiency confirmed not to result in loss of operability.

This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program Component, because Entergy did not take appropriate corrective actions to address safety issues in a timely manner. Specifically, Entergy did not take action to determine the degradation rate of the 10S581 RHRSW strainer which resulted in a through wall leak. (IMC 0310, Aspect P.1 (d)) (1 R21.2.1.3) Inspection Report# : [2010006](#) (*pdf*)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Fire Barrier Penetrations Not Maintained as Qualified Three Hour Fire Barriers

A self-revealing non-cited violation (NCV) of very low safety significance of license condition 2.C(3), “Fire Protection,” was identified because Entergy personnel did not implement and maintain in effect all provisions of the approved fire protection program when multiple electrical and mechanical three hour fire barrier penetrations were not qualified to perform their required three hour fire barrier function. Entergy initiated condition report (CR)-JAF-2010-01417, CR-JAF-2010-01432, CR-JAF-2010-01438, and CR-JAF-2010-01441 to address the issues, implemented fire watches as compensatory measures, poured new qualified seals, and revised maintenance procedures for installing penetration seals to explicitly describe the need to pre-mix the powder component with the liquid elastomer.

This finding is more than minor because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, multiple fire barrier penetrations were not qualified to perform their required three hour fire barrier function and provided a barrier to fire that was less than that provided by the properly installed and qualified fire barriers. The inspectors determined the significance of the finding using Inspection Manual Chapter (IMC) 0609, Appendix F, “Fire Protection Significance Determination Process,” Phase 1. The finding was determined to be of very low safety significance (Green) because the deficiency represented a low degradation rating, since the non-qualified seals consisted of base components which had been qualified as three hour fire barriers at other nuclear facilities. The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the work practices component because Entergy personnel proceeded in the face of unexpected circumstances when the packaging for the kits changed and when kits were issued without a powder component.

Inspection Report# : [2010003](#) (*pdf*)

Significance: SL-IV Mar 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER for a Condition Prohibited by TS Associated with HPCI

The inspectors identified a Severity Level IV, non-cited violation (NCV) because Entergy did not provide a written report to the NRC within 60 days after discovery of the event as required by 10 CFR 50.73, “Licensee Event Report (LER) System,” for a condition which was prohibited by Technical Specification (TS) 3.5.1, “Emergency Core Cooling Systems - Operating.”

In January, 2009, the high pressure coolant injection (HPCI) system did not pass post-maintenance testing, as a result of the failure of the HPCI system turbine stop valve 23HOV-1, to stroke open within the required time. Entergy personnel documented the condition in CR-JAF-2009-0350. The inservice test (IST) opening time for 23HOV-1 had previously exceeded the correct acceptance criteria which should have resulted in declaring the HPCI system inoperable. The inspectors determined that this condition met the criteria for reporting under 10 CFR 50.73 (a)(2)(i) (B) in that the condition was not allowed by the plant’s TSs. Entergy’s corrective actions included initiating CR-JAF-2009-03964, submitting LER 05000333/2009008-00 on January 11, 2010, and providing additional guidance for their staff on licensee event reporting requirements.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using the traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement I, "Reactor Operations," example D4 which states, "A failure to make a required LER;" the NRC determined that this violation could potentially impact the regulatory process and is more than minor and categorized as a Severity Level IV violation.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution within the corrective action program component because Entergy personnel did not properly evaluate the condition reporting criteria.

Inspection Report# : [2010002](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Emergency Lighting Not Monitored in Accordance with 10 CFR Part 50.65 (a)(1)

The inspectors identified an NCV of 10 CFR Part 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy staff did not demonstrate that the performance of the emergency lighting system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1). Specifically, the inspectors identified that a second emergency light failure had not been correctly classified as a functional failure as documented in condition report (CR)-JAF-2009-02768, initiated on August 12, 2009. The issue was entered into Entergy's corrective action program (CAP) as CR-JAF-2009-02999 and Entergy classified the emergency lighting system (a)(1) due to this repeat failure. Additionally, the emergency lighting battery preventive maintenance replacement period was reduced from 24 months to 18 months due to an excessive number of emergency lighting battery failures that occurred between 18 and 24 months.

This finding is more than minor because it affected the external factors attribute (fire) of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, plant operators rely on emergency lighting to provide lighting to complete actions described in emergency operating procedures in case of a partial or complete loss of normal plant lighting. Additionally, Appendix R emergency lighting supports time critical post-fire safe shutdown manual actions and the availability of the emergency lighting battery system was affected. The emergency lighting system had not been maintained sufficiently to provide for reliable operation of the equipment.

The inspectors determined the significance of the finding using IMC 0609, Appendix F, "Fire Protection Significance Determination Process." This finding affected post-fire safe shutdown. The finding was determined to be of very low safety significance (Green) because the inspectors assigned a low degradation rating in phase 1 of the SDP. The inspectors assigned a low degradation rating because the issue did not have a significant impact on safe shutdown operations: operators, carry flashlights, the three emergency portable lighting units located in the control room were available, and there were not specific plant areas that had widespread emergency lighting outages at any one time.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution within the CAP component because Entergy personnel did not address an adverse trend in the emergency lighting battery system in a timely manner. (P.1(d))

Inspection Report# : [2009005](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Standby Liquid Control Not Monitored in Accordance with 10 CFR Part 50.65 (a)(1)

The inspectors identified an NCV of 10 CFR Part 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Entergy staff did not demonstrate that the performance of the standby liquid control (SLC) system had been effectively controlled through the performance of appropriate preventive

maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1). Entergy initiated CR-JAF-2009-03994 and CR-JAF-2009-04017 to address the issues and classified the SLC system as (a)(1) due to the repetitive maintenance preventable failures and the incomplete corrective actions related to increasing the PM frequency from every two months to once a month.

The inspectors determined the finding is more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, plant operators rely on the SLC tank level indication in the control room for performing actions required by emergency operating procedures and the availability of this indication was affected.

The inspectors determined the significance of the finding using IMC 0609.04, “Phase 1 – Initial Screening and Characterization of Findings.” The finding was determined to be of very low safety significance (Green) because it was not a design or qualification deficiency; did not represent a loss of system safety function; and did not screen as potentially risk-significant due to external initiating events. Specifically, the loss of control indication did not render the SLC system incapable of injecting borated water into the reactor coolant system, and operators remained capable of measuring the level of the SLC tank locally using manual dipping.

The inspectors determined this finding had a cross-cutting aspect in the area of problem identification and resolution within the CAP component because Entergy personnel did not address an adverse trend in the SLC tank level indication in a timely manner. (P.1(d))

Inspection Report# : [2009005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : November 29, 2010

FitzPatrick

4Q/2010 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure for Refueling Water Level Control Resulted in Overflowing of Reactor Cavity Water in the Reactor Building

A self-revealing NCV of very low safety significance of technical specification (TS) 5.4, "Procedures," was identified because Entergy procedure OP-30A, "Refueling Water Level Control," did not provide adequate guidance to operators for filling the reactor cavity which resulted in the reactor building (RB) floor drains overflowing and water intrusion from higher to lower levels in the RB. Entergy personnel entered this issue into their corrective action program (CAP), (CR-JAF-2010-05406 and CR-JAF-2010-05407) and performed several actions to ensure proper water level control prior to the next drain down of the reactor cavity. These actions included revising OP-30A to provide sufficient detail, ensuring additional detail would be included in pre-job briefings to include potential drain paths from the reactor cavity and spent fuel pool, and installing a dedicated camera to monitor reactor cavity water level.

This finding is more than minor because it is associated with the procedure quality attribute of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown. Specifically, water spray throughout areas of the RB created a potential for water entering motors, valve operators, motor control centers, circuit breakers, and electrical junction boxes, such that electrical components could have been compromised, which increased the likelihood of an event that would upset plant stability and challenge a critical safety function. The inspectors determined the significance of the finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance because Entergy personnel maintained an adequate mitigation capability and there was there neither an inadvertent loss of two feet of RCS inventory nor an inadvertent reactor coolant system pressurization.

The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the resources component because the procedure used for filling the reactor cavity was not sufficiently complete to assure nuclear safety. (H.2(c) per IMC 0310).

Inspection Report# : [2010005](#) (*pdf*)

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Equipment Status Control for a Manually Operated Normally Locked Open Residual Heat Removal Injection Valve

A self-revealing NCV of very low safety significance of TS 5.4, "Procedures," was identified because Entergy personnel did not implement AP-12.06, "Equipment Status Control," as required. Specifically, Entergy personnel did not maintain status control and properly document the position of the residual heat removal (RHR) to reactor water recirculation loop 'B' isolation valve (10RHR-818) as closed nor did operators restore the valve to its normal locked open position upon completion of a leak surveillance test. Entergy personnel entered this issue into their corrective action program (CAP), (CR-JAF-2010-06656) and promptly restored the valve to its required locked open position.

This finding is more than minor because it is associated with the configuration control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the operators did not maintain configuration control of the RHR isolation valve and restore the valve to a locked open position when the 'B' RHR subsystem was credited for maintaining acceptable shutdown risk. The inspectors determined the significance of the finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." The issue was determined to screen as very low safety significance (Green) because the 'B' RHR train could be considered available with respect to Appendix G, Section 4.0, and Attachment 3, Section 2.2.3. Specifically, the inspectors determined that operators had more than twice the time available (with a shortest time to boil of 5.8 hours) than would have been required to identify and take action to restore/open the RHR isolation valve in the event of a loss of shutdown cooling or RCS inventory.

This finding had a cross-cutting aspect in the Human Performance cross-cutting area, Work Practices component, because Entergy personnel did not define and effectively communicate expectations regarding procedural compliance, and personnel did not follow procedures (H.4(b) per IMC 0310).

Inspection Report# : [2010005](#) (*pdf*)

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Appendix R Fire Door Blocked Open Without Establishing Required Measures

The inspectors identified a non-cited violation (NCV) of very low safety significance of license condition 2.C(3), "Fire Protection," because Entergy personnel blocked a fire door in the open position, defeating its required three hour fire barrier function, without establishing the required compensatory measures. Entergy entered this issue into their CAP as CR-JAF-2010-04825, issued a night order emphasizing the requirements associated with propping open fire doors, provided coaching, and submitted a procedure change request to further clarify procedural applicability requirements.

This finding is more than minor because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the fire door being affixed open without the knowledge of the control room personnel and other operators and without an assigned fire watch resulted in a barrier to fire propagation that was less robust than required by the approved fire protection program. The inspectors determined the significance of the finding using IMC 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance (Green) because the deficiency represented a low degradation rating. Specifically, the individuals involved were members of the fire brigade, qualified in fire watch duties, and only blocked the door open during resin container transfers. The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the work practices component because Entergy did not effectively communicate expectations to personnel regarding

the applicable procedures and personnel did not follow the procedures (H.4(b)).

Inspection Report# : [2010004](#) (pdf)

Significance: G Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Use Largest Load During EDG Reject Surveillance Test

The team identified a finding involving a non-cited violation of James A. FitzPatrick Technical Specification (TS) Surveillance Requirement (SR) 3.8.1.8 because Entergy did not adequately perform the largest post-accident load rejection test as required by the SR. Specifically, Entergy's surveillance test that implemented this SR rejected a load of about 1000 brake horse power (BHP) and the largest post-accident load calculated by Entergy was 1270 BHP. Entergy entered this issue into their corrective action program to evaluate operability of each emergency diesel generator (EDG) subsystem and to correct the surveillance test for rejection of the largest postaccident load. The team reviewed Entergy's operability determination and concluded it appropriately determined the EDG subsystems were operable but non-conforming to SR 3.8.1.8.

This finding is more than minor because it is associated with the Procedure Quality Attribute (maintenance and testing) of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating event to prevent undesirable consequences. The team performed a Phase 1 SDP screening, in accordance with NRC IMC 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," and determined the finding was of very low safety Significance (Green) because it was a qualification deficiency confirmed not to result in loss of operability.

The team did not identify a cross-cutting aspect associated with the finding because the performance deficiency occurred during the historical development of ST-9C, Emergency AC Power Load Sequencing Test and 4KV Emergency Power System Voltage Relays Instrument Functional Test. The team determined there was not a reasonable opportunity to identify the deficiency during the recent past. Therefore, the issue was determined not to be indicative of current licensee performance. (1 R21.2.1.1)

Inspection Report# : [2010006](#) (pdf)

Significance: G Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Calculations for Offsite Power Availability

The team identified a finding involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," in that Entergy did not verify the adequacy of design with respect to establishing the basis for the offsite power minimum voltage and the degraded voltage relay reset setpoint. Specifically, Entergy failed to adequately evaluate the results of load flow studies that determined safety bus voltage would be below the relay reset value following some design basis events. The team concluded that this could result in separation of the vital busses from the offsite power supply during some design basis events. Entergy entered this issue in the corrective action program to verify offsite power was operable, and instructed the offsite grid operator to raise the minimum grid voltage limit and revise the post accident grid loading profile. The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of very low safety significance (Green) because it was a design deficiency confirmed not to result in a loss of the offsite power supply operability or functionality.

This finding had a cross-cutting aspect in the area of Human Performance Resources

because the licensee did not ensure that personnel, equipment, procedures, and other resources are available to ensure complete, accurate and up-to-date design documentation. Specifically, the acceptance criteria in the recently completed calculations that evaluated the offsite power voltage limit was not correct which resulted in an incorrect evaluation of the results of the calculation. (IMC 0310, Section H.2(c)) (1 R21.2.1.2)

Inspection Report# : [2010006](#) (*pdf*)

Significance:  Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Action on RHRSW Strainer Housing Wall Degradation

The team identified a finding involving a non-cited violation of 10 CFR 50, Appendix 8, Criterion XVI, "Corrective Actions," for failure to identify and correct a condition adverse to quality. Specifically, Entergy did not take corrective actions to evaluate the rate of identified degradation on the 1 OS-58 1 residual heat removal service water (RHRSW) strainer casing. This resulted in a through wall leak in the strainer which was identified by the team. The team's review found that in 2006 Entergy had conducted ultrasonic test (UT) measurements of the strainer and determined that degradation was occurring. Corrective actions for the deficiency required that a UT examination be performed to monitor for further degradation but it was not performed. In response, Entergy entered the issue into the corrective action program, and conducted an UT examination at the leak location to determine the size and extent of the defect which determined that strainer's structural integrity was maintained.

The finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of very low safety significance (Green) because the finding was determined to be a qualification deficiency confirmed not to result in loss of operability.

This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program Component, because Entergy did not take appropriate corrective actions to address safety issues in a timely manner. Specifically, Entergy did not take action to determine the degradation rate of the 10S581 RHRSW strainer which resulted in a through wall leak. (IMC 0310, Aspect P.1 (d)) (1 R21.2.1.3)
Inspection Report# : [2010006](#) (*pdf*)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Fire Barrier Penetrations Not Maintained as Qualified Three Hour Fire Barriers

A self-revealing non-cited violation (NCV) of very low safety significance of license condition 2.C(3), "Fire Protection," was identified because Entergy personnel did not implement and maintain in effect all provisions of the approved fire protection program when multiple electrical and mechanical three hour fire barrier penetrations were not qualified to perform their required three hour fire barrier function. Entergy initiated condition report (CR)-JAF-2010-01417, CR-JAF-2010-01432, CR-JAF-2010-01438, and CR-JAF-2010-01441 to address the issues, implemented fire watches as compensatory measures, poured new qualified seals, and revised maintenance procedures for installing penetration seals to explicitly describe the need to pre-mix the powder component with the liquid elastomer.

This finding is more than minor because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, multiple fire barrier penetrations were not qualified to perform their required three hour fire barrier function and provided a barrier to fire that was less than that provided by the properly installed and qualified fire barriers. The inspectors determined the significance of the finding using Inspection Manual Chapter (IMC) 0609, Appendix F, "Fire Protection Significance

Determination Process,” Phase 1. The finding was determined to be of very low safety significance (Green) because the deficiency represented a low degradation rating, since the non-qualified seals consisted of base components which had been qualified as three hour fire barriers at other nuclear facilities. The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the work practices component because Entergy personnel proceeded in the face of unexpected circumstances when the packaging for the kits changed and when kits were issued without a powder component.

Inspection Report# : [2010003](#) (pdf)

Significance: SL-IV Mar 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER for a Condition Prohibited by TS Associated with HPCI

The inspectors identified a Severity Level IV, non-cited violation (NCV) because Entergy did not provide a written report to the NRC within 60 days after discovery of the event as required by 10 CFR 50.73, “Licensee Event Report (LER) System,” for a condition which was prohibited by Technical Specification (TS) 3.5.1, “Emergency Core Cooling Systems - Operating.”

In January, 2009, the high pressure coolant injection (HPCI) system did not pass post-maintenance testing, as a result of the failure of the HPCI system turbine stop valve 23HOV-1, to stroke open within the required time. Entergy personnel documented the condition in CR-JAF-2009-0350. The inservice test (IST) opening time for 23HOV-1 had previously exceeded the correct acceptance criteria which should have resulted in declaring the HPCI system inoperable. The inspectors determined that this condition met the criteria for reporting under 10 CFR 50.73 (a)(2)(i) (B) in that the condition was not allowed by the plant’s TSs. Entergy’s corrective actions included initiating CR-JAF-2009-03964, submitting LER 05000333/2009008-00 on January 11, 2010, and providing additional guidance for their staff on licensee event reporting requirements.

This violation involved a failure to make a required report to the NRC and is considered to impact the regulatory process. Such violations are dispositioned using the traditional enforcement process instead of the Significance Determination Process. Using the Enforcement Policy Supplement I, “Reactor Operations,” example D4 which states, “A failure to make a required LER;” the NRC determined that this violation could potentially impact the regulatory process and is more than minor and categorized as a Severity Level IV violation.

The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution within the corrective action program component because Entergy personnel did not properly evaluate the condition reporting criteria.

Inspection Report# : [2010002](#) (pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Dec 03, 2010

Identified By: NRC

Item Type: FIN Finding

2010 FitzPatrick PIR Team Summary

The team concluded that Entergy personnel were generally effective in identifying, evaluating, and resolving problems. In most instances, FitzPatrick personnel identified problems at a low threshold and entered them into the Corrective Action Program (CAP). The team determined that FitzPatrick staff screened issues appropriately for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Causal analyses appropriately considered extent of condition, generic issues, and previous occurrences. The team determined that corrective actions addressed the identified causes and were implemented in a timely manner.

Entergy's audits and self-assessments reviewed by the team were thorough and probing. Additionally, the team concluded that Entergy personnel, in general, adequately identified, reviewed, and applied relevant industry operating experience (OE) to FitzPatrick. Based on interviews, observations of plant activities, and reviews of the CAP and the Employee Concerns Program (ECP), the team did not identify concerns with site personnel's willingness to raise safety issues nor did the team identify conditions that indicated a negative impact on the site's safety conscious work environment.

Inspection Report# : [2010007](#) (*pdf*)

Last modified : March 03, 2011

FitzPatrick

1Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Control Room Envelope Inoperable due to Unlatched Boundary Door

The inspectors identified a non-cited violation (NCV) of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," because Entergy personnel did not identify and correct a condition adverse to quality related to a control room envelope (CRE) boundary door. Specifically, Entergy personnel did not identify and implement adequate actions to ensure the safety-related CRE boundary door, 70DOR-A-300-5, remained latched and able to perform its safety function. As corrective action, the foreign material that prevented the door from consistently latching was removed by Entergy personnel. The issue was entered into the corrective action program (CAP) as condition reports CR-JAF-2010-08617 and CR-JAF-2011-00407.

The finding was more than minor because it was associated with the configuration control and the barrier performance attributes specific to the radiological barrier function of the control room. The finding affected the Barrier Integrity cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations," based on a Phase 3 analysis. The inspectors determined the period that the door was potentially open was small relative to the technical specification (TS) allowed outage time, and therefore represented very low safety significance, considering the low probability of a design basis accident during that time period.

The finding had a cross-cutting aspect in the area of problem identification and resolution within the corrective action program component because Entergy personnel did not completely and accurately identify the degraded condition of the door.

Inspection Report# : [2011002](#) (*pdf*)

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure for Refueling Water Level Control Resulted in Overflowing of Reactor Cavity Water in the Reactor Building

A self-revealing NCV of very low safety significance of technical specification (TS) 5.4, "Procedures," was identified because Entergy procedure OP-30A, "Refueling Water Level Control," did not provide adequate guidance to operators for filling the reactor cavity which resulted in the reactor building (RB) floor drains overflowing and water intrusion from higher to lower levels in the RB. Entergy personnel entered this issue into their corrective action program (CAP), (CR-JAF-2010-05406 and CR-JAF-2010-05407) and performed several actions to ensure proper water level control prior to the next drain down of the reactor cavity. These actions included revising OP-30A to provide sufficient detail, ensuring additional detail would be included in pre-job briefings to include potential drain paths from the

reactor cavity and spent fuel pool, and installing a dedicated camera to monitor reactor cavity water level.

This finding is more than minor because it is associated with the procedure quality attribute of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown. Specifically, water spray throughout areas of the RB created a potential for water entering motors, valve operators, motor control centers, circuit breakers, and electrical junction boxes, such that electrical components could have been compromised, which increased the likelihood of an event that would upset plant stability and challenge a critical safety function. The inspectors determined the significance of the finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance because Entergy personnel maintained an adequate mitigation capability and there was there neither an inadvertent loss of two feet of RCS inventory nor an inadvertent reactor coolant system pressurization.

The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the resources component because the procedure used for filling the reactor cavity was not sufficiently complete to assure nuclear safety. (H.2(c) per IMC 0310).

Inspection Report# : [2010005](#) (*pdf*)

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Equipment Status Control for a Manually Operated Normally Locked Open Residual Heat Removal Injection Valve

A self-revealing NCV of very low safety significance of TS 5.4, "Procedures," was identified because Entergy personnel did not implement AP-12.06, "Equipment Status Control," as required. Specifically, Entergy personnel did not maintain status control and properly document the position of the residual heat removal (RHR) to reactor water recirculation loop 'B' isolation valve (10RHR-818) as closed nor did operators restore the valve to its normal locked open position upon completion of a leak surveillance test. Entergy personnel entered this issue into their corrective action program (CAP), (CR-JAF-2010-06656) and promptly restored the valve to its required locked open position.

This finding is more than minor because it is associated with the configuration control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the operators did not maintain configuration control of the RHR isolation valve and restore the valve to a locked open position when the 'B' RHR subsystem was credited for maintaining acceptable shutdown risk. The inspectors determined the significance of the finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." The issue was determined to screen as very low safety significance (Green) because the 'B' RHR train could be considered available with respect to Appendix G, Section 4.0, and Attachment 3, Section 2,2.3. Specifically, the inspectors determined that operators had more than twice the time available (with a shortest time to boil of 5.8 hours) than would have been required to identify and take action to restore/open the RHR isolation valve in the event of a loss of shutdown cooling or RCS inventory.

This finding had a cross-cutting aspect in the Human Performance cross-cutting

area, Work Practices component, because Entergy personnel did not define and effectively communicate expectations regarding procedural compliance, and personnel did not follow procedures (H.4(b) per IMC 0310).

Inspection Report# : [2010005](#) (*pdf*)

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Appendix R Fire Door Blocked Open Without Establishing Required Measures

The inspectors identified a non-cited violation (NCV) of very low safety significance of license condition 2.C(3), "Fire Protection," because Entergy personnel blocked a fire door in the open position, defeating its required three hour fire barrier function, without establishing the required compensatory measures. Entergy entered this issue into their CAP as CR-JAF-2010-04825, issued a night order emphasizing the requirements associated with propping open fire doors, provided coaching, and submitted a procedure change request to further clarify procedural applicability requirements.

This finding is more than minor because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the fire door being affixed open without the knowledge of the control room personnel and other operators and without an assigned fire watch resulted in a barrier to fire propagation that was less robust than required by the approved fire protection program. The inspectors determined the significance of the finding using IMC 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance (Green) because the deficiency represented a low degradation rating. Specifically, the individuals involved were members of the fire brigade, qualified in fire watch duties, and only blocked the door open during resin container transfers. The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the work practices component because Entergy did not effectively communicate expectations to personnel regarding the applicable procedures and personnel did not follow the procedures (H.4(b)).

Inspection Report# : [2010004](#) (*pdf*)

Significance:  Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Use Largest Load During EDG Reject Surveillance Test

The team identified a finding involving a non-cited violation of James A. FitzPatrick Technical Specification (TS) Surveillance Requirement (SR) 3.8.1.8 because Entergy did not adequately perform the largest post-accident load rejection test as required by the SR. Specifically, Entergy's surveillance test that implemented this SR rejected a load of about 1000 brake horse power (BHP) and the largest post-accident load calculated by Entergy was 1270 BHP. Entergy entered this issue into their corrective action program to evaluate operability of each emergency diesel generator (EDG) subsystem and to correct the surveillance test for rejection of the largest postaccident load. The team reviewed Entergy's operability determination and concluded it appropriately determined the EDG subsystems were operable but non-conforming to SR 3.8.1.8.

This finding is more than minor because it is associated with the Procedure Quality Attribute (maintenance and testing) of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating event to prevent undesirable consequences. The team performed a Phase 1 SDP screening, in accordance with NRC IMC 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," and determined the finding was of very low safety Significance (Green) because it was a qualification deficiency confirmed not to result in loss of operability.

The team did not identify a cross-cutting aspect associated with the finding because the

performance deficiency occurred during the historical development of ST-9C, Emergency AC Power Load Sequencing Test and 4KV Emergency Power System Voltage Relays Instrument Functional Test. The team determined there was not a reasonable opportunity to identify the deficiency during the recent past. Therefore, the issue was determined not to be indicative of current licensee performance. (1 R21.2.1.1)

Inspection Report# : [2010006](#) (*pdf*)

Significance: G Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Calculations for Offsite Power Availability

The team identified a finding involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," in that Entergy did not verify the adequacy of design with respect to establishing the basis for the offsite power minimum voltage and the degraded voltage relay reset setpoint. Specifically, Entergy failed to adequately evaluate the results of load flow studies that determined safety bus voltage would be below the relay reset value following some design basis events. The team concluded that this could result in separation of the vital busses from the offsite power supply during some design basis events. Entergy entered this issue in the corrective action program to verify offsite power was operable, and instructed the offsite grid operator to raise the minimum grid voltage limit and revise the post accident grid loading profile. The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of very low safety significance (Green) because it was a design deficiency confirmed not to result in a loss of the offsite power supply operability or functionality.

This finding had a cross-cutting aspect in the area of Human Performance Resources because the licensee did not ensure that personnel, equipment, procedures, and other resources are available to ensure complete, accurate and up-to-date design documentation. Specifically, the acceptance criteria in the recently completed calculations that evaluated the offsite power voltage limit was not correct which resulted in an incorrect evaluation of the results of the calculation. (IMC 0310, Section H.2(c))

(1 R21.2.1.2)

Inspection Report# : [2010006](#) (*pdf*)

Significance: G Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Action on RHRSW Strainer Housing Wall Degradation

The team identified a finding involving a non-cited violation of 10 CFR 50, Appendix 8, Criterion XVI, "Corrective Actions," for failure to identify and correct a condition adverse to quality. Specifically, Entergy did not take corrective actions to evaluate the rate of identified degradation on the 1 OS-58 1 residual heat removal service water (RHRSW) strainer casing. This resulted in a through wall leak in the strainer which was identified by the team. The team's review found that in 2006 Entergy had conducted ultrasonic test (UT) measurements of the strainer and determined that degradation was occurring. Corrective actions for the deficiency required that a UT examination be performed to monitor for further degradation but it was not performed. In response, Entergy entered the issue into the corrective action program, and conducted an UT examination at the leak location to determine the size and extent of the defect which determined that strainer's structural integrity was maintained.

The finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of

very low safety significance (Green) because the finding was determined to be a qualification deficiency confirmed not to result in loss of operability. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program Component, because Entergy did not take appropriate corrective actions to address safety issues in a timely manner. Specifically, Entergy did not take action to determine the degradation rate of the 10S581 RHRSW strainer which resulted in a through wall leak. (IMC 0310, Aspect P.1 (d)) (1 R21.2.1.3) Inspection Report# : [2010006](#) (*pdf*)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Fire Barrier Penetrations Not Maintained as Qualified Three Hour Fire Barriers

A self-revealing non-cited violation (NCV) of very low safety significance of license condition 2.C(3), “Fire Protection,” was identified because Entergy personnel did not implement and maintain in effect all provisions of the approved fire protection program when multiple electrical and mechanical three hour fire barrier penetrations were not qualified to perform their required three hour fire barrier function. Entergy initiated condition report (CR)-JAF-2010-01417, CR-JAF-2010-01432, CR-JAF-2010-01438, and CR-JAF-2010-01441 to address the issues, implemented fire watches as compensatory measures, poured new qualified seals, and revised maintenance procedures for installing penetration seals to explicitly describe the need to pre-mix the powder component with the liquid elastomer.

This finding is more than minor because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, multiple fire barrier penetrations were not qualified to perform their required three hour fire barrier function and provided a barrier to fire that was less than that provided by the properly installed and qualified fire barriers. The inspectors determined the significance of the finding using Inspection Manual Chapter (IMC) 0609, Appendix F, “Fire Protection Significance Determination Process,” Phase 1. The finding was determined to be of very low safety significance (Green) because the deficiency represented a low degradation rating, since the non-qualified seals consisted of base components which had been qualified as three hour fire barriers at other nuclear facilities. The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the work practices component because Entergy personnel proceeded in the face of unexpected circumstances when the packaging for the kits changed and when kits were issued without a powder component.

Inspection Report# : [2010003](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Dec 03, 2010

Identified By: NRC

Item Type: FIN Finding

2010 FitzPatrick PIR Team Summary

The team concluded that Entergy personnel were generally effective in identifying, evaluating, and resolving problems. In most instances, FitzPatrick personnel identified problems at a low threshold and entered them into the Corrective Action Program (CAP). The team determined that FitzPatrick staff screened issues appropriately for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Causal analyses appropriately considered extent of condition, generic issues, and previous occurrences. The team determined that corrective actions addressed the identified causes and were implemented in a timely manner.

Entergy's audits and self-assessments reviewed by the team were thorough and probing. Additionally, the team concluded that Entergy personnel, in general, adequately identified, reviewed, and applied relevant industry operating experience (OE) to FitzPatrick. Based on interviews, observations of plant activities, and reviews of the CAP and the Employee Concerns Program (ECP), the team did not identify concerns with site personnel's willingness to raise safety issues nor did the team identify conditions that indicated a negative impact on the site's safety conscious work environment.

Inspection Report# : [2010007](#) (*pdf*)

Last modified : June 07, 2011

FitzPatrick

2Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: SL-IV Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

UFSAR Emergency Bus Voltage Not Updated, Consistent with Current Plant Conditions

The inspectors identified a Severity Level IV (SL IV) NCV of Title 10, Code of Federal Regulations (10 CFR) Part 50.71(e) because FitzPatrick personnel did not update the Updated Final Safety Analysis Report (UFSAR) with information consistent with plant conditions. Specifically, FitzPatrick personnel did not remove reference to or correct information in UFSAR Section 8.6.6.c, "Emergency Bus Voltages When Operating From the Reserve Source," to reflect current plant conditions with regard to the listed maximum voltage capable of being produced at the emergency bus from the reserve source during a low load condition. This issue was considered within the traditional enforcement process because it had the potential to impede or impact the NRC's ability to perform its regulatory functions. FitzPatrick issued condition report (CR) CR-JAF-2011-03023 to address the UFSAR discrepancy.

The inspectors concluded that the violation was more than minor because the longstanding and incorrect information in the UFSAR had a potential impact on safety and licensed activities. Excessive voltage on an emergency bus can result in equipment damage, or loss due to the actuation of protective devices such as overcurrent fuses. Similar to Enforcement Policy Section 6.1, example D.3, the inspectors determined the violation was of SL IV because the erroneous information not updated in the UFSAR was not used to make an unacceptable change to the facility nor did it impact a licensing or safety decision by the Nuclear Regulatory Commission (NRC).

Inspection Report# : [2011003](#) (*pdf*)

Significance:  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Control Room Envelope Inoperable due to Unlatched Boundary Door

The inspectors identified a non-cited violation (NCV) of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," because Entergy personnel did not identify and correct a condition adverse to quality related to a control room envelope (CRE) boundary door. Specifically, Entergy personnel did not identify and implement adequate actions to ensure the safety-related CRE boundary door, 70DOR-A-300-5, remained latched and able to perform its safety function. As corrective action, the foreign material that prevented the door from consistently latching was removed by Entergy personnel. The issue was entered into the corrective action program (CAP) as condition reports CR-JAF-2010-08617 and CR-JAF-2011-00407.

The finding was more than minor because it was associated with the configuration control and the barrier performance attributes specific to the radiological barrier function of the control room. The finding affected the Barrier Integrity cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations," based on a Phase 3 analysis. The inspectors determined the period that the door was potentially open was small relative to the technical specification (TS) allowed outage time, and therefore represented very low safety significance, considering the low probability of a design basis accident during that time period.

The finding had a cross-cutting aspect in the area of problem identification and resolution within the corrective action program component because Entergy personnel did not completely and accurately identify the degraded condition of the door.

Inspection Report# : [2011002](#) (*pdf*)

Significance:  Dec 31, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Procedure for Refueling Water Level Control Resulted in Overflowing of Reactor Cavity Water in the Reactor Building

A self-revealing NCV of very low safety significance of technical specification (TS) 5.4, "Procedures," was identified because Entergy procedure OP-30A, "Refueling Water Level Control," did not provide adequate guidance to operators for filling the reactor cavity which resulted in the reactor building (RB) floor drains overflowing and water intrusion from higher to lower levels in the RB. Entergy personnel entered this issue into their corrective action program (CAP), (CR-JAF-2010-05406 and CR-JAF-2010-05407) and performed several actions to ensure proper water level control prior to the next drain down of the reactor cavity. These actions included revising OP-30A to provide sufficient detail, ensuring additional detail would be included in pre-job briefings to include potential drain paths from the reactor cavity and spent fuel pool, and installing a dedicated camera to monitor reactor cavity water level.

This finding is more than minor because it is associated with the procedure quality attribute of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown. Specifically, water spray throughout areas of the RB created a potential for water entering motors, valve operators, motor control centers, circuit breakers, and electrical junction boxes, such that electrical components could have been compromised, which increased the likelihood of an event that would upset plant stability and challenge a critical safety function. The inspectors determined the significance of the finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance because Entergy personnel maintained an adequate mitigation capability and there was there neither an inadvertent loss of two feet of RCS inventory nor an inadvertent reactor coolant system pressurization.

The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the resources component because the procedure used for filling the reactor cavity was not sufficiently complete to assure nuclear safety. (H.2(c) per IMC 0310).

Inspection Report# : [2010005](#) (*pdf*)

Significance:  Dec 31, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Maintain Equipment Status Control for a Manually Operated Normally Locked Open Residual Heat Removal Injection Valve

A self-revealing NCV of very low safety significance of TS 5.4, "Procedures," was identified because Entergy personnel did not implement AP-12.06, "Equipment Status Control," as required. Specifically, Entergy personnel did not maintain status control and properly document the position of the residual heat removal (RHR) to reactor water recirculation loop 'B' isolation valve (10RHR-818) as closed nor did

operators restore the valve to its normal locked open position upon completion of a leak surveillance test. Entergy personnel entered this issue into their corrective action program (CAP), (CR-JAF-2010-06656) and promptly restored the valve to its required locked open position.

This finding is more than minor because it is associated with the configuration control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the operators did not maintain configuration control of the RHR isolation valve and restore the valve to a locked open position when the 'B' RHR subsystem was credited for maintaining acceptable shutdown risk. The inspectors determined the significance of the finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." The issue was determined to screen as very low safety significance (Green) because the 'B' RHR train could be considered available with respect to Appendix G, Section 4.0, and Attachment 3, Section 2,2.3. Specifically, the inspectors determined that operators had more than twice the time available (with a shortest time to boil of 5.8 hours) than would have been required to identify and take action to restore/open the RHR isolation valve in the event of a loss of shutdown cooling or RCS inventory.

This finding had a cross-cutting aspect in the Human Performance cross-cutting area, Work Practices component, because Entergy personnel did not define and effectively communicate expectations regarding procedural compliance, and personnel did not follow procedures (H.4(b) per IMC 0310).

Inspection Report# : [2010005](#) (*pdf*)

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Appendix R Fire Door Blocked Open Without Establishing Required Measures

The inspectors identified a non-cited violation (NCV) of very low safety significance of license condition 2.C(3), "Fire Protection," because Entergy personnel blocked a fire door in the open position, defeating its required three hour fire barrier function, without establishing the required compensatory measures. Entergy entered this issue into their CAP as CR-JAF-2010-04825, issued a night order emphasizing the requirements associated with propping open fire doors, provided coaching, and submitted a procedure change request to further clarify procedural applicability requirements.

This finding is more than minor because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the fire door being affixed open without the knowledge of the control room personnel and other operators and without an assigned fire watch resulted in a barrier to fire propagation that was less robust than required by the approved fire protection program. The inspectors determined the significance of the finding using IMC 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance (Green) because the deficiency represented a low degradation rating. Specifically, the individuals involved were members of the fire brigade, qualified in fire watch duties, and only blocked the door open during resin container transfers. The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the work practices component because Entergy did not effectively communicate expectations to personnel regarding the applicable procedures and personnel did not follow the procedures (H.4(b)).

Inspection Report# : [2010004](#) (*pdf*)

Significance:  Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Use Largest Load During EDG Reject Surveillance Test

The team identified a finding involving a non-cited violation of James A. FitzPatrick Technical Specification (TS) Surveillance Requirement (SR) 3.8.1.8 because Entergy did not adequately perform the largest post-accident load rejection test as required by the SR. Specifically, Entergy's surveillance test that implemented this SR rejected a load of about 1000 brake horse power (BHP) and the largest post-accident load calculated by Entergy was 1270 BHP. Entergy entered this issue into their corrective action program to evaluate operability of each emergency diesel generator (EDG) subsystem and to correct the surveillance test for rejection of the largest postaccident load. The team reviewed Entergy's operability determination and concluded it appropriately determined the EDG subsystems were operable but non-conforming to SR 3.8.1.8.

This finding is more than minor because it is associated with the Procedure Quality Attribute (maintenance and testing) of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating event to prevent undesirable consequences. The team performed a Phase 1 SDP screening, in accordance with NRC IMC 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," and determined the finding was of very low safety Significance (Green) because it was a qualification deficiency confirmed not to result in loss of operability.

The team did not identify a cross-cutting aspect associated with the finding because the performance deficiency occurred during the historical development of ST-9C, Emergency AC Power Load Sequencing Test and 4KV Emergency Power System Voltage Relays Instrument Functional Test. The team determined there was not a reasonable opportunity to identify the deficiency during the recent past. Therefore, the issue was determined not to be indicative of current licensee performance. (1 R21.2.1.1)
Inspection Report# : [2010006](#) (*pdf*)

Significance:  Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Calculations for Offsite Power Availability

The team identified a finding involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," in that Entergy did not verify the adequacy of design with respect to establishing the basis for the offsite power minimum voltage and the degraded voltage relay reset setpoint. Specifically, Entergy failed to adequately evaluate the results of load flow studies that determined safety bus voltage would be below the relay reset value following some design basis events. The team concluded that this could result in separation of the vital busses from the offsite power supply during some design basis events. Entergy entered this issue in the corrective action program to verify offsite power was operable, and instructed the offsite grid operator to raise the minimum grid voltage limit and revise the post accident grid loading profile. The finding is more than minor because it is associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of very low safety significance (Green) because it was a design deficiency confirmed not to result in a loss of the offsite power supply operability or functionality.

This finding had a cross-cutting aspect in the area of Human Performance Resources because the licensee did not ensure that personnel, equipment, procedures, and other resources are available to ensure complete, accurate and up-to-date design documentation. Specifically, the acceptance criteria in the recently completed calculations that evaluated the offsite power voltage limit was not correct which resulted in an incorrect evaluation of the results of the calculation. (IMC 0310, Section H.2(c)) (1 R21.2.1.2)

Inspection Report# : [2010006](#) (*pdf*)

Significance: G Jul 02, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Action on RHRSW Strainer Housing Wall Degradation

The team identified a finding involving a non-cited violation of 10 CFR 50, Appendix 8, Criterion XVI, "Corrective Actions," for failure to identify and correct a condition adverse to quality. Specifically, Entergy did not take corrective actions to evaluate the rate of identified degradation on the 1 OS-58 1 residual heat removal service water (RHRSW) strainer casing. This resulted in a through wall leak in the strainer which was identified by the team. The team's review found that in 2006 Entergy had conducted ultrasonic test (UT) measurements of the strainer and determined that degradation was occurring. Corrective actions for the deficiency required that a UT examination be performed to monitor for further degradation but it was not performed. In response, Entergy entered the issue into the corrective action program, and conducted an UT examination at the leak location to determine the size and extent of the defect which determined that strainer's structural integrity was maintained.

The finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of very low safety significance (Green) because the finding was determined to be a qualification deficiency confirmed not to result in loss of operability.

This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program Component, because Entergy did not take appropriate corrective actions to address safety issues in a timely manner. Specifically, Entergy did not take action to determine the degradation rate of the 10S581 RHRSW strainer which resulted in a through wall leak. (IMC 0310, Aspect P.1 (d)) (1 R21.2.1.3) Inspection Report# : [2010006](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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Miscellaneous

Significance: N/A Dec 03, 2010

Identified By: NRC

Item Type: FIN Finding

2010 FitzPatrick PIR Team Summary

The team concluded that Entergy personnel were generally effective in identifying, evaluating, and resolving problems. In most instances, FitzPatrick personnel identified problems at a low threshold and entered them into the Corrective Action Program (CAP). The team determined that FitzPatrick staff screened issues appropriately for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Causal analyses appropriately considered extent of condition, generic issues, and previous occurrences. The team determined that corrective actions addressed the identified causes and were implemented in a timely manner.

Entergy's audits and self-assessments reviewed by the team were thorough and probing. Additionally, the team concluded that Entergy personnel, in general, adequately identified, reviewed, and applied relevant industry operating experience (OE) to FitzPatrick. Based on interviews, observations of plant activities, and reviews of the CAP and the Employee Concerns Program (ECP), the team did not identify concerns with site personnel's willingness to raise safety issues nor did the team identify conditions that indicated a negative impact on the site's safety conscious work environment.

Inspection Report# : [2010007](#) (*pdf*)

Last modified : October 14, 2011

FitzPatrick

3Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: SL-IV Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

UFSAR Emergency Bus Voltage Not Updated, Consistent with Current Plant Conditions

The inspectors identified a Severity Level IV (SL IV) NCV of Title 10, Code of Federal Regulations (10 CFR) Part 50.71(e) because FitzPatrick personnel did not update the Updated Final Safety Analysis Report (UFSAR) with information consistent with plant conditions. Specifically, FitzPatrick personnel did not remove reference to or correct information in UFSAR Section 8.6.6.c, "Emergency Bus Voltages When Operating From the Reserve Source," to reflect current plant conditions with regard to the listed maximum voltage capable of being produced at the emergency bus from the reserve source during a low load condition. This issue was considered within the traditional enforcement process because it had the potential to impede or impact the NRC's ability to perform its regulatory functions. FitzPatrick issued condition report (CR) CR-JAF-2011-03023 to address the UFSAR discrepancy.

The inspectors concluded that the violation was more than minor because the longstanding and incorrect information in the UFSAR had a potential impact on safety and licensed activities. Excessive voltage on an emergency bus can result in equipment damage, or loss due to the actuation of protective devices such as overcurrent fuses. Similar to Enforcement Policy Section 6.1, example D.3, the inspectors determined the violation was of SL IV because the erroneous information not updated in the UFSAR was not used to make an unacceptable change to the facility nor did it impact a licensing or safety decision by the Nuclear Regulatory Commission (NRC).

Inspection Report# : [2011003](#) (*pdf*)

Significance:  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Control Room Envelope Inoperable due to Unlatched Boundary Door

The inspectors identified a non-cited violation (NCV) of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," because Entergy personnel did not identify and correct a condition adverse to quality related to a control room envelope (CRE) boundary door. Specifically, Entergy personnel did not identify and implement adequate actions to ensure the safety-related CRE boundary door, 70DOR-A-300-5, remained latched and able to perform its safety function. As corrective action, the foreign material that prevented the door from consistently latching was removed by Entergy personnel. The issue was entered into the corrective action program (CAP) as condition reports CR-JAF-2010-08617 and CR-JAF-2011-00407.

The finding was more than minor because it was associated with the configuration control and the barrier performance attributes specific to the radiological barrier function of the control room. The finding affected the Barrier Integrity cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations," based on a Phase 3 analysis. The inspectors determined the period that the door was potentially open was small relative to the technical specification (TS) allowed outage time, and therefore represented very low safety significance, considering the low probability of a design basis accident during that time period.

The finding had a cross-cutting aspect in the area of problem identification and resolution within the corrective action program component because Entergy personnel did not completely and accurately identify the degraded condition of the door.

Inspection Report# : [2011002](#) (*pdf*)

Significance:  Dec 31, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Procedure for Refueling Water Level Control Resulted in Overflowing of Reactor Cavity Water in the Reactor Building

A self-revealing NCV of very low safety significance of technical specification (TS) 5.4, "Procedures," was identified because Entergy procedure OP-30A, "Refueling Water Level Control," did not provide adequate guidance to operators for filling the reactor cavity which resulted in the reactor building (RB) floor drains overflowing and water intrusion from higher to lower levels in the RB. Entergy personnel entered this issue into their corrective action program (CAP), (CR-JAF-2010-05406 and CR-JAF-2010-05407) and performed several actions to ensure proper water level control prior to the next drain down of the reactor cavity. These actions included revising OP-30A to provide sufficient detail, ensuring additional detail would be included in pre-job briefings to include potential drain paths from the reactor cavity and spent fuel pool, and installing a dedicated camera to monitor reactor cavity water level.

This finding is more than minor because it is associated with the procedure quality attribute of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown. Specifically, water spray throughout areas of the RB created a potential for water entering motors, valve operators, motor control centers, circuit breakers, and electrical junction boxes, such that electrical components could have been compromised, which increased the likelihood of an event that would upset plant stability and challenge a critical safety function. The inspectors determined the significance of the finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," Phase 1. The finding was determined to be of very low safety significance because Entergy personnel maintained an adequate mitigation capability and there was there neither an inadvertent loss of two feet of RCS inventory nor an inadvertent reactor coolant system pressurization.

The inspectors determined this finding had a cross-cutting aspect in the area of human performance within the resources component because the procedure used for filling the reactor cavity was not sufficiently complete to assure nuclear safety. (H.2(c) per IMC 0310).

Inspection Report# : [2010005](#) (*pdf*)

Significance:  Dec 31, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Maintain Equipment Status Control for a Manually Operated Normally Locked Open Residual Heat Removal Injection Valve

A self-revealing NCV of very low safety significance of TS 5.4, "Procedures," was identified because Entergy personnel did not implement AP-12.06, "Equipment Status Control," as required. Specifically, Entergy personnel did not maintain status control and properly document the position of the residual heat removal (RHR) to reactor water recirculation loop 'B' isolation valve (10RHR-818) as closed nor did

operators restore the valve to its normal locked open position upon completion of a leak surveillance test. Entergy personnel entered this issue into their corrective action program (CAP), (CR-JAF-2010-06656) and promptly restored the valve to its required locked open position.

This finding is more than minor because it is associated with the configuration control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the operators did not maintain configuration control of the RHR isolation valve and restore the valve to a locked open position when the 'B' RHR subsystem was credited for maintaining acceptable shutdown risk. The inspectors determined the significance of the finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." The issue was determined to screen as very low safety significance (Green) because the 'B' RHR train could be considered available with respect to Appendix G, Section 4.0, and Attachment 3, Section 2,2.3. Specifically, the inspectors determined that operators had more than twice the time available (with a shortest time to boil of 5.8 hours) than would have been required to identify and take action to restore/open the RHR isolation valve in the event of a loss of shutdown cooling or RCS inventory.

This finding had a cross-cutting aspect in the Human Performance cross-cutting area, Work Practices component, because Entergy personnel did not define and effectively communicate expectations regarding procedural compliance, and personnel did not follow procedures (H.4(b) per IMC 0310).
Inspection Report# : [2010005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Dec 03, 2010

Identified By: NRC

Item Type: FIN Finding

2010 FitzPatrick PIR Team Summary

The team concluded that Entergy personnel were generally effective in identifying, evaluating, and resolving problems. In most instances, FitzPatrick personnel identified problems at a low threshold and entered them into the Corrective Action Program (CAP). The team determined that FitzPatrick staff screened issues appropriately for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Causal analyses appropriately considered extent of condition, generic issues, and previous occurrences. The team determined that corrective actions addressed the identified causes and were implemented in a timely manner.

Entergy's audits and self-assessments reviewed by the team were thorough and probing. Additionally, the team concluded that Entergy personnel, in general, adequately identified, reviewed, and applied relevant industry operating experience (OE) to FitzPatrick. Based on interviews, observations of plant activities, and reviews of the CAP and the Employee Concerns Program (ECP), the team did not identify concerns with site personnel's willingness to raise safety issues nor did the team identify conditions that indicated a negative impact on the site's safety conscious work environment.

Inspection Report# : [2010007](#) (*pdf*)

Last modified : January 04, 2012

FitzPatrick

4Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Mode Switch in Shutdown Scram Function Inoperable in Excess of the TS Allowed Outage Time due to Personnel Error

The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 3.3.1.1, "Reactor Protection System (RPS) Instrumentation," because FitzPatrick operators did not take required action within the allowed completion time in response to an RPS relay failure. Specifically, following failure of RPS channel 'B' shutdown scram reset interlock logic relay 5A-K17B, which caused the reactor mode switch to shutdown manual scram to be disabled, action was not taken by operators to insert a half-scrum on RPS channel 'B' within one hour as required by TS 3.3.1.1 Condition C. After further evaluation of the issue, operators inserted a half scram on RPS channel 'B'. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2011-06625.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the delay in implementing the TS required actions resulted in additional accrual of more than two hours of reactor operation with the reactor mode switch to shutdown manual scram bypassed. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance (Green). This finding had a cross-cutting aspect in the area of Human Performance, decision making, because operators did not use conservative assumptions in decision making and promptly apply readily available information contained in the alarm response procedure and TS Bases to determine TS applicability for the alarm condition [H.1(b) per IMC0310]. (Section 1R13)

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Ineffective Corrective Action for RCIC Steam Admission Valve Malfunction

The inspectors identified a self-revealing NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because Entergy personnel did not promptly correct the intermittent failure of reactor core isolation cooling (RCIC) steam admission valve 13MOV-131 to fully open on demand. Specifically, Entergy staff's troubleshooting performed in response to the October 29, 2010, partial valve opening was not adequate in scope to identify the cause of the intermittent failure. As corrective action, a more extensive troubleshooting effort was undertaken by Entergy staff following a second failure of the valve to fully open on January 7, 2011, which was successful at identifying and correcting the problem. The issue was entered into the CAP as CR-JAF-2011-00123.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems

cornerstone objective to ensure reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the loose electrical connections in the 13MOV-131 motor control circuit affected the reliability of the RCIC system. Since the RCIC pump achieved rated discharge flow and pressure on both occasions that 13MOV-131 failed to fully open, the inspectors concluded that RCIC remained capable of performing its design function during the period that this condition existed. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance (Green). The finding had a cross-cutting aspect in the area of Human Performance, work control, because Entergy personnel did not appropriately plan the scope of 13MOV-131 troubleshooting activity by incorporating consideration of the high risk significance of the RCIC system [H.3 (a) per IMC0310]. (Section 4OA3)

Inspection Report# : [2011005](#) (*pdf*)

Significance: SL-IV Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

UFSAR Emergency Bus Voltage Not Updated, Consistent with Current Plant Conditions

The inspectors identified a Severity Level IV (SL IV) NCV of Title 10, Code of Federal Regulations (10 CFR) Part 50.71(e) because FitzPatrick personnel did not update the Updated Final Safety Analysis Report (UFSAR) with information consistent with plant conditions. Specifically, FitzPatrick personnel did not remove reference to or correct information in UFSAR Section 8.6.6.c, "Emergency Bus Voltages When Operating From the Reserve Source," to reflect current plant conditions with regard to the listed maximum voltage capable of being produced at the emergency bus from the reserve source during a low load condition. This issue was considered within the traditional enforcement process because it had the potential to impede or impact the NRC's ability to perform its regulatory functions. FitzPatrick issued condition report (CR) CR-JAF-2011-03023 to address the UFSAR discrepancy.

The inspectors concluded that the violation was more than minor because the longstanding and incorrect information in the UFSAR had a potential impact on safety and licensed activities. Excessive voltage on an emergency bus can result in equipment damage, or loss due to the actuation of protective devices such as overcurrent fuses. Similar to Enforcement Policy Section 6.1, example D.3, the inspectors determined the violation was of SL IV because the erroneous information not updated in the UFSAR was not used to make an unacceptable change to the facility nor did it impact a licensing or safety decision by the Nuclear Regulatory Commission (NRC).

Inspection Report# : [2011003](#) (*pdf*)

Significance:  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Control Room Envelope Inoperable due to Unlatched Boundary Door

The inspectors identified a non-cited violation (NCV) of very low safety significance of 10 CFR 50, Criterion XVI, "Corrective Action," because Entergy personnel did not identify and correct a condition adverse to quality related to a control room envelope (CRE) boundary door. Specifically, Entergy personnel did not identify and implement adequate actions to ensure the safety-related CRE boundary door, 70DOR-A-300-5, remained latched and able to perform its safety function. As corrective action, the foreign material that prevented the door from consistently latching was removed by Entergy personnel. The issue was entered into the corrective action program (CAP) as condition reports CR-JAF-2010-08617 and CR-JAF-2011-00407.

The finding was more than minor because it was associated with the configuration control and the barrier performance attributes specific to the radiological barrier function of the control room. The finding affected the Barrier Integrity cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations," based on a Phase 3 analysis. The inspectors

determined the period that the door was potentially open was small relative to the technical specification (TS) allowed outage time, and therefore represented very low safety significance, considering the low probability of a design basis accident during that time period.

The finding had a cross-cutting aspect in the area of problem identification and resolution within the corrective action program component because Entergy personnel did not completely and accurately identify the degraded condition of the door.

Inspection Report# : [2011002](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Work Planning for 'A' Reactor Recirculation Pump Replacement.

The inspectors identified a self-revealing finding that involved inadequate work planning relative to the 'A' recirculation pump replacement work during refueling outage R19 that resulted in additional unplanned collective exposure (39.168 person-rem compared to a work activity estimate of 15.831 person-rem). The actual job site conditions were not adequately evaluated by Entergy staff for interferences and the support work was not coordinated to prevent additional unnecessary exposure and did not meet the Radiation Work Permit (RWP) No. 10-0518 planned dose execution for the work activity. This inadequate evaluation lead to as-found interferences that required removal and reinstallation, and insufficient outage schedule coordination that resulted in several scaffold interferences with other outage tasks that caused avoidable scaffold rework and in unintended exposure that could have been avoided by Entergy personnel.

The finding was more than minor because it was associated with the Radiation Safety -Occupational Radiation Safety cornerstone attribute of program and process, and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, inadequate work planning resulted in unplanned, unintended collective exposure that was greater than 50 percent above the intended collective exposure and greater than five person-rem due to conditions that were reasonably within Entergy's ability to foresee and correct. The inspectors evaluated the finding using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," and determined that the finding was of very low safety significance (Green) because the finding was due to As Low As Reasonably Achievable (ALARA) work control planning and the three year rolling average collective exposure at FitzPatrick was less than 240 person-rem (146.593 person-rem for 2008-2010). The finding had a cross-cutting aspect in the area of Human Performance, work control, because Entergy's planned work activities did not adequately incorporate work site interferences or outage work coordination in the work control planning process [H.3 (b) per IMC0310]. (Section 2RS2)

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Radiation Protection Procedures

The inspectors identified a self-revealing NCV of TS 5.4, "Procedures," which requires that written procedures be implemented covering the activities in the applicable procedures recommended by Regulatory Guide 1.33, including procedures for RWPs and ALARA reviews. Specifically, as of December 12, 2011, post job reviews for most of the 2010 R-19 RWPs (52 of 55) had not been completed as required by procedure EN-RP-105, "Radiological Work Permits," Revision 10. This procedure requires post job reviews to be completed within 90 days from the end of the outage. The performance deficiency could lead to repeating errors and not planning the upcoming R-20 with needed improvements. Since planning for the R-20 outage had already begun, the inspectors concluded that lessons learned in the R-19 outage RWPs may not be incorporated into the R-20 RWPs and additional, avoidable exposure could be received. Entergy staff subsequently developed a tracking schedule to complete the reviews and entered the issue into the CAP as CR-JAF-2011-04152.

The finding was more than minor because it was associated with the Radiation Safety -Occupational Radiation Safety cornerstone attribute of program and process, and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, Entergy staff did not complete RWP close out documentation to identify lessons learned and actions to reduce worker exposure in subsequent refueling outages. The inspectors evaluated the finding using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," and determined that the finding was of very low safety significance (Green) because it did not involve: (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. The finding had a cross-cutting aspect in the area of Human Performance, work practices, because Entergy personnel did not effectively communicate expectations regarding procedural compliance [H.4(b) per IMC0310]. (Section 2RS2)

Inspection Report# : [2011005](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (pdf)

Last modified : March 02, 2012

FitzPatrick

1Q/2012 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: N/A Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER Revision for a Condition Prohibited by TS Associated with the HPCI System

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of 10 CFR Part 50.73, "Licensee Event Report [LER] System," because a violation of Technical Specification (TS) 3.5.1.G for the condition of the high pressure coolant injection (HPCI) and reactor core isolation cooling (RCIC) systems being simultaneously inoperable was not reported to the NRC within 60 days of discovery. After this was identified by the inspectors, the issue was entered into Entergy's corrective action program (CAP) as CR-JAF-2011-04779. Entergy subsequently submitted Revision 1 to LERs 05000333/2010-005-00 and 05000333/2011-001-00.

The inspectors determined that the failure to revise LER 05000333/2010-005-00 within 60 days to include the violation of TS 3.5.1.G in accordance with 10 CFR Part 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct, and should have been prevented. Because the issue impacted the regulatory process, in that a violation of site Technical Specifications was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel did not make a report required by 10 CFR Part 50.73. In accordance with Inspection Manual Chapter (IMC) 0612, Appendix B, traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2012002](#) (*pdf*)

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Mode Switch in Shutdown Scram Function Inoperable in Excess of the TS Allowed Outage Time due to Personnel Error

The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 3.3.1.1, "Reactor Protection System (RPS) Instrumentation," because FitzPatrick operators did not take required action within the allowed completion time in response to an RPS relay failure. Specifically, following failure of RPS channel 'B' shutdown scram reset interlock logic relay 5A-K17B, which caused the reactor mode switch to shutdown manual scram to be disabled, action was not taken by operators to insert a half-scrum on RPS channel 'B' within one hour as required by TS 3.3.1.1 Condition C. After further evaluation of the issue, operators inserted a half scram on RPS channel 'B'. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2011-06625.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the delay in implementing the TS required actions resulted in additional accrual of more than two hours of reactor operation with the reactor mode switch to shutdown manual scram bypassed. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined this finding was not a

design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance (Green). This finding had a cross-cutting aspect in the area of Human Performance, decision making, because operators did not use conservative assumptions in decision making and promptly apply readily available information contained in the alarm response procedure and TS Bases to determine TS applicability for the alarm condition [H.1(b) per IMC0310]. (Section 1R13)

Inspection Report# : [2011005](#) (pdf)

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Ineffective Corrective Action for RCIC Steam Admission Valve Malfunction

The inspectors identified a self-revealing NCV of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Action,” because Entergy personnel did not promptly correct the intermittent failure of reactor core isolation cooling (RCIC) steam admission valve 13MOV-131 to fully open on demand. Specifically, Entergy staff’s troubleshooting performed in response to the October 29, 2010, partial valve opening was not adequate in scope to identify the cause of the intermittent failure. As corrective action, a more extensive troubleshooting effort was undertaken by Entergy staff following a second failure of the valve to fully open on January 7, 2011, which was successful at identifying and correcting the problem. The issue was entered into the CAP as CR-JAF-2011-00123.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the loose electrical connections in the 13MOV-131 motor control circuit affected the reliability of the RCIC system. Since the RCIC pump achieved rated discharge flow and pressure on both occasions that 13MOV-131 failed to fully open, the inspectors concluded that RCIC remained capable of performing its design function during the period that this condition existed. The inspectors evaluated the finding using the Phase 1, “Initial Screening and Characterization of Findings,” worksheet in Attachment 4 to IMC 0609, "Significance Determination Process.” The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance (Green). The finding had a cross-cutting aspect in the area of Human Performance, work control, because Entergy personnel did not appropriately plan the scope of 13MOV-131 troubleshooting activity by incorporating consideration of the high risk significance of the RCIC system [H.3 (a) per IMC0310]. (Section 4OA3)

Inspection Report# : [2011005](#) (pdf)

Significance: SL-IV Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

UFSAR Emergency Bus Voltage Not Updated, Consistent with Current Plant Conditions

The inspectors identified a Severity Level IV (SL IV) NCV of Title 10, Code of Federal Regulations (10 CFR) Part 50.71(e) because FitzPatrick personnel did not update the Updated Final Safety Analysis Report (UFSAR) with information consistent with plant conditions. Specifically, FitzPatrick personnel did not remove reference to or correct information in UFSAR Section 8.6.6.c, “Emergency Bus Voltages When Operating From the Reserve Source,” to reflect current plant conditions with regard to the listed maximum voltage capable of being produced at the emergency bus from the reserve source during a low load condition. This issue was considered within the traditional enforcement process because it had the potential to impede or impact the NRC's ability to perform its regulatory functions. FitzPatrick issued condition report (CR) CR-JAF-2011-03023 to address the UFSAR discrepancy.

The inspectors concluded that the violation was more than minor because the longstanding and incorrect information in the UFSAR had a potential impact on safety and licensed activities. Excessive voltage on an emergency bus can result in equipment damage, or loss due to the actuation of protective devices such as overcurrent fuses. Similar to Enforcement Policy Section 6.1, example D.3, the inspectors determined the violation was of SL IV because the

erroneous information not updated in the UFSAR was not used to make an unacceptable change to the facility nor did it impact a licensing or safety decision by the Nuclear Regulatory Commission (NRC).

Inspection Report# : [2011003](#) (pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Work Planning for 'A' Reactor Recirculation Pump Replacement.

The inspectors identified a self-revealing finding that involved inadequate work planning relative to the 'A' recirculation pump replacement work during refueling outage R19 that resulted in additional unplanned collective exposure (39.168 person-rem compared to a work activity estimate of 15.831 person-rem). The actual job site conditions were not adequately evaluated by Entergy staff for interferences and the support work was not coordinated to prevent additional unnecessary exposure and did not meet the Radiation Work Permit (RWP) No. 10-0518 planned dose execution for the work activity. This inadequate evaluation lead to as-found interferences that required removal and reinstallation, and insufficient outage schedule coordination that resulted in several scaffold interferences with other outage tasks that caused avoidable scaffold rework and in unintended exposure that could have been avoided by Entergy personnel.

The finding was more than minor because it was associated with the Radiation Safety -Occupational Radiation Safety cornerstone attribute of program and process, and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, inadequate work planning resulted in unplanned, unintended collective exposure that was greater than 50 percent above the intended collective exposure and greater than five person-rem due to conditions that were reasonably within Entergy's ability to foresee and correct. The inspectors evaluated the finding using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," and determined that the finding was of very low safety significance (Green) because the finding was due to As Low As Reasonably Achievable (ALARA) work control planning and the three year rolling average collective exposure at FitzPatrick was less than 240 person-rem (146.593 person-rem for 2008-2010). The finding had a cross-cutting aspect in the area of Human Performance, work control, because Entergy's planned work activities did not adequately incorporate work site interferences or outage work coordination in the work control planning process [H.3 (b) per IMC0310]. (Section 2RS2)

Inspection Report# : [2011005](#) (pdf)

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Radiation Protection Procedures

The inspectors identified a self-revealing NCV of TS 5.4, "Procedures," which requires that written procedures be implemented covering the activities in the applicable procedures recommended by Regulatory Guide 1.33, including procedures for RWPs and ALARA reviews. Specifically, as of December 12, 2011, post job reviews for most of the 2010 R-19 RWPs (52 of 55) had not been completed as required by procedure EN-RP-105, "Radiological Work

Permits," Revision 10. This procedure requires post job reviews to be completed within 90 days from the end of the outage. The performance deficiency could lead to repeating errors and not planning the upcoming R-20 with needed improvements. Since planning for the R-20 outage had already begun, the inspectors concluded that lessons learned in the R-19 outage RWPs may not be incorporated into the R-20 RWPs and additional, avoidable exposure could be received. Entergy staff subsequently developed a tracking schedule to complete the reviews and entered the issue into the CAP as CR-JAF-2011-04152.

The finding was more than minor because it was associated with the Radiation Safety -Occupational Radiation Safety cornerstone attribute of program and process, and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, Entergy staff did not complete RWP close out documentation to identify lessons learned and actions to reduce worker exposure in subsequent refueling outages. The inspectors evaluated the finding using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," and determined that the finding was of very low safety significance (Green) because it did not involve: (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. The finding had a cross-cutting aspect in the area of Human Performance, work practices, because Entergy personnel did not effectively communicate expectations regarding procedural compliance [H.4(b) per IMC0310]. (Section 2RS2)

Inspection Report# : [2011005](#) (*pdf*)

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : May 29, 2012

FitzPatrick

2Q/2012 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Procedure for Installation of Reactor Water Recirculation Motor-Generator Scoop Tube Positioners

The inspectors identified a self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy staff did not provide adequate procedures for installation of a plant modification to replace the reactor water recirculation (RWR) motor-generator (MG) scoop tube positioners during the 2010 refueling outage. Specifically, excessive torque was specified for use on positioner ball joint fasteners, which damaged one of the ball joints and resulted in subsequent binding during attempted operation. As a result, on November 11, 2010, the 'B' RWR MG scoop tube positioner bound when operators attempted to reduce pump speed, and released the following day which resulted in an unexpected power reduction of approximately 1.5 percent (40 megawatts thermal (MWt)). As immediate corrective action, control room operators reduced flow in the 'A' RWR loop to restore compliance with the TS requirement for balanced loop flow, then locked the scoop tubes for both RWR MGs pending further evaluation of the event. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2010-07782.

The finding was more than minor because it was similar to example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that it resulted in a plant transient. The finding also affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined the finding was not a loss of coolant accident or external events initiator, and did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Therefore, the inspectors determined the finding to be of very low safety significance. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because Design Engineering personnel did not ensure that accurate design documentation and procedures were available to assure successful implementation of the RWR MG scoop tube positioner modification [H.2(c)]. (Section 4OA2)

Inspection Report# : [2012003](#) (*pdf*)

Mitigating Systems

Significance:  Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Procedure During Removal from Service of Emergency Diesel Generator Ventilation

The inspectors identified a self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy personnel did not adequately implement procedures when removing the ventilation system for the 'A' emergency diesel generator (EDG) subsystem from service. Specifically, operators did not implement tagout placement instructions, which required that the affected EDGs be declared inoperable once the ventilation system was tagged out. Additionally, control room operators did not respond to the resultant 'A' EDG ventilation system common alarm in accordance with the alarm response procedure, which also would have led to the

EDGs being declared inoperable. As a result, TS 3.8.1 was not entered in a timely manner and the TS surveillance requirement was not performed within the specified completion time. As immediate corrective action, the 'A' EDG subsystem was declared inoperable and the specified surveillance requirement was completed. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-02591.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the offsite electrical circuits were not verified available by operators for approximately three hours while the 'A' EDG subsystem was inoperable. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to Inspection Manual Chapter (IMC) 0609, "Significance Determination Process." The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices, because operators did not follow procedures [H.4(b)]. (Section 1R13)

Inspection Report# : [2012003](#) (pdf)

Significance: N/A Apr 24, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

NRC Not Notified of a Licensed Operator's Change in Medical Status

The inspectors identified a Severity Level IV NCV of 10 CFR 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, Entergy did not notify the NRC within 30 days of discovering a change in medical condition for a licensed operator. Subsequently, Entergy submitted a notification for the operator on February 15, 2012, and entered the issue into their corrective action program (CR-JAF-2012-00576). The inspectors determined that Entergy's failure to notify the NRC within 30 days of discovering the change in medical condition for the licensed operator was a performance deficiency that was within Entergy personnel's ability to foresee and correct and should have been prevented. The inspectors determined that traditional enforcement applies, as the issue had the potential to impact the NRC's ability to perform its regulatory function.

The significance of the associated performance deficiency was screened against the ROP per the guidance of IMC 0612, Appendix B. No associated ROP finding was identified and no cross-cutting aspect was assigned. This issue is similar to violation example 6.4'd.1 (a) in the NRC Enforcement Policy for a Severity Level IV violation because it involves noncompliance with medical requirements where the operator did not perform the functions of a licensed operator while having the potentially disqualifying medical condition. (Section 4OA5)

Inspection Report# : [2012301](#) (pdf)

Significance: N/A Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER Revision for a Condition Prohibited by TS Associated with the HPCI System

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of 10 CFR Part 50.73, "Licensee Event Report [LER] System," because a violation of Technical Specification (TS) 3.5.1.G for the condition of the high pressure coolant injection (HPCI) and reactor core isolation cooling (RCIC) systems being simultaneously inoperable was not reported to the NRC within 60 days of discovery. After this was identified by the inspectors, the issue was entered into Entergy's corrective action program (CAP) as CR-JAF-2011-04779. Entergy subsequently submitted Revision 1 to LERs 05000333/2010-005-00 and 05000333/2011-001-00.

The inspectors determined that the failure to revise LER 05000333/2010-005-00 within 60 days to include the violation of TS 3.5.1.G in accordance with 10 CFR Part 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct, and should have been prevented. Because the issue impacted the regulatory process, in that a violation of site Technical Specifications was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement

Policy, the inspectors determined the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel did not make a report required by 10 CFR Part 50.73. In accordance with Inspection Manual Chapter (IMC) 0612, Appendix B, traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2012002](#) (pdf)

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Mode Switch in Shutdown Scram Function Inoperable in Excess of the TS Allowed Outage Time due to Personnel Error

The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 3.3.1.1, "Reactor Protection System (RPS) Instrumentation," because FitzPatrick operators did not take required action within the allowed completion time in response to an RPS relay failure. Specifically, following failure of RPS channel 'B' shutdown scram reset interlock logic relay 5A-K17B, which caused the reactor mode switch to shutdown manual scram to be disabled, action was not taken by operators to insert a half-scrum on RPS channel 'B' within one hour as required by TS 3.3.1.1 Condition C. After further evaluation of the issue, operators inserted a half scram on RPS channel 'B'. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2011-06625.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the delay in implementing the TS required actions resulted in additional accrual of more than two hours of reactor operation with the reactor mode switch to shutdown manual scram bypassed. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance (Green). This finding had a cross-cutting aspect in the area of Human Performance, decision making, because operators did not use conservative assumptions in decision making and promptly apply readily available information contained in the alarm response procedure and TS Bases to determine TS applicability for the alarm condition [H.1(b) per IMC0310]. (Section 1R13)

Inspection Report# : [2011005](#) (pdf)

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Ineffective Corrective Action for RCIC Steam Admission Valve Malfunction

The inspectors identified a self-revealing NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because Entergy personnel did not promptly correct the intermittent failure of reactor core isolation cooling (RCIC) steam admission valve 13MOV-131 to fully open on demand. Specifically, Entergy staff's troubleshooting performed in response to the October 29, 2010, partial valve opening was not adequate in scope to identify the cause of the intermittent failure. As corrective action, a more extensive troubleshooting effort was undertaken by Entergy staff following a second failure of the valve to fully open on January 7, 2011, which was successful at identifying and correcting the problem. The issue was entered into the CAP as CR-JAF-2011-00123.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the loose electrical connections in the 13MOV-131 motor control circuit affected the reliability of the RCIC system. Since the RCIC pump achieved rated discharge flow and pressure on both occasions that 13MOV-131 failed to fully open, the inspectors concluded that RCIC remained capable of performing its design function during the period that this condition existed. The inspectors evaluated the finding using the Phase 1, "Initial

Screening and Characterization of Findings,” worksheet in Attachment 4 to IMC 0609, "Significance Determination Process.” The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance (Green). The finding had a cross-cutting aspect in the area of Human Performance, work control, because Entergy personnel did not appropriately plan the scope of 13MOV-131 troubleshooting activity by incorporating consideration of the high risk significance of the RCIC system [H.3 (a) per IMC0310]. (Section 4OA3)

Inspection Report# : [2011005](#) (pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Work Planning for 'A' Reactor Recirculation Pump Replacement.

The inspectors identified a self-revealing finding that involved inadequate work planning relative to the 'A' recirculation pump replacement work during refueling outage R19 that resulted in additional unplanned collective exposure (39.168 person-rem compared to a work activity estimate of 15.831 person-rem). The actual job site conditions were not adequately evaluated by Entergy staff for interferences and the support work was not coordinated to prevent additional unnecessary exposure and did not meet the Radiation Work Permit (RWP) No. 10-0518 planned dose execution for the work activity. This inadequate evaluation lead to as-found interferences that required removal and reinstallation, and insufficient outage schedule coordination that resulted in several scaffold interferences with other outage tasks that caused avoidable scaffold rework and in unintended exposure that could have been avoided by Entergy personnel.

The finding was more than minor because it was associated with the Radiation Safety -Occupational Radiation Safety cornerstone attribute of program and process, and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, inadequate work planning resulted in unplanned, unintended collective exposure that was greater than 50 percent above the intended collective exposure and greater than five person-rem due to conditions that were reasonably within Entergy’s ability to foresee and correct. The inspectors evaluated the finding using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," and determined that the finding was of very low safety significance (Green) because the finding was due to As Low As Reasonably Achievable (ALARA) work control planning and the three year rolling average collective exposure at FitzPatrick was less than 240 person-rem (146.593 person-rem for 2008-2010). The finding had a cross-cutting aspect in the area of Human Performance, work control, because Entergy’s planned work activities did not adequately incorporate work site interferences or outage work coordination in the work control planning process [H.3 (b) per IMC0310]. (Section 2RS2)

Inspection Report# : [2011005](#) (pdf)

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Radiation Protection Procedures

The inspectors identified a self-revealing NCV of TS 5.4, "Procedures," which requires that written procedures be implemented covering the activities in the applicable procedures recommended by Regulatory Guide 1.33, including procedures for RWPs and ALARA reviews. Specifically, as of December 12, 2011, post job reviews for most of the 2010 R-19 RWPs (52 of 55) had not been completed as required by procedure EN-RP-105, "Radiological Work Permits," Revision 10. This procedure requires post job reviews to be completed within 90 days from the end of the outage. The performance deficiency could lead to repeating errors and not planning the upcoming R-20 with needed improvements. Since planning for the R-20 outage had already begun, the inspectors concluded that lessons learned in the R-19 outage RWPs may not be incorporated into the R-20 RWPs and additional, avoidable exposure could be received. Entergy staff subsequently developed a tracking schedule to complete the reviews and entered the issue into the CAP as CR-JAF-2011-04152.

The finding was more than minor because it was associated with the Radiation Safety -Occupational Radiation Safety cornerstone attribute of program and process, and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, Entergy staff did not complete RWP close out documentation to identify lessons learned and actions to reduce worker exposure in subsequent refueling outages. The inspectors evaluated the finding using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," and determined that the finding was of very low safety significance (Green) because it did not involve: (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. The finding had a cross-cutting aspect in the area of Human Performance, work practices, because Entergy personnel did not effectively communicate expectations regarding procedural compliance [H.4(b) per IMC0310]. (Section 2RS2)

Inspection Report# : [2011005](#) (*pdf*)

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Mar 16, 2012

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. James A. FitzPatrick Nuclear Power Plant (FitzPatrick) personnel identified problems, entered them into the corrective action program (CAP) at a low threshold, and prioritized issues commensurate with their safety significance. In most cases, station personnel appropriately screened issues for operability and reportability, and performed causal analyses

that appropriately considered extent-of-condition, generic issues, and previous occurrences. The inspectors also determined that Entergy personnel typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Entergy adequately identified, reviewed, and applied relevant industry operating experience to FitzPatrick operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were self-critical and thorough. Station personnel effectively identified and elevated adverse performance trends for senior site management review through use of the Entergy Trending Process.

Based on interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify indications that site personnel were unwilling to raise safety issues nor did they identify conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2012008](#) (*pdf*)

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : September 12, 2012

FitzPatrick 3Q/2012 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Procedure for Installation of Reactor Water Recirculation Motor-Generator Scoop Tube Positioners

The inspectors identified a self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy staff did not provide adequate procedures for installation of a plant modification to replace the reactor water recirculation (RWR) motor-generator (MG) scoop tube positioners during the 2010 refueling outage. Specifically, excessive torque was specified for use on positioner ball joint fasteners, which damaged one of the ball joints and resulted in subsequent binding during attempted operation. As a result, on November 11, 2010, the 'B' RWR MG scoop tube positioner bound when operators attempted to reduce pump speed, and released the following day which resulted in an unexpected power reduction of approximately 1.5 percent (40 megawatts thermal (MWt)). As immediate corrective action, control room operators reduced flow in the 'A' RWR loop to restore compliance with the TS requirement for balanced loop flow, then locked the scoop tubes for both RWR MGs pending further evaluation of the event. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2010-07782.

The finding was more than minor because it was similar to example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that it resulted in a plant transient. The finding also affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined the finding was not a loss of coolant accident or external events initiator, and did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Therefore, the inspectors determined the finding to be of very low safety significance. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because Design Engineering personnel did not ensure that accurate design documentation and procedures were available to assure successful implementation of the RWR MG scoop tube positioner modification [H.2(c)]. (Section 4OA2)

Inspection Report# : [2012003](#) (*pdf*)

Mitigating Systems

Significance: G Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Corrective Action to Address Crescent Area Unit Cooler Operability

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix

B, Criterion XVI, “Corrective Action,” because FitzPatrick staff did not take timely corrective action to verify that a crescent area unit cooler was operable under postulated conditions of degraded grid voltage. Specifically, FitzPatrick staff did not schedule first time low voltage pickup testing for unit cooler 66UC-22B until after summer lake temperature had increased to the point that removing the unit cooler from service would have challenged the temperature limit for ultimate heat sink (UHS) operability. When the test was later performed, the as-found pickup voltage exceeded the maximum allowed by the procedure and required a case-specific analysis to demonstrate operability. As immediate corrective action, FitzPatrick electricians cleaned the contact assembly and retested the unit, with satisfactory results. FitzPatrick staff entered this issue into the corrective action program as condition report (CR)-JAF-2012-04443.

The finding was more than minor because it was similar to example 3.i in Inspection Manual Chapter (IMC) 0612, Appendix E, “Examples of Minor Issues,” in that a case-specific engineering analysis was required to assure the accident analysis requirements were met. The finding also affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding in accordance with IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” and determined that the finding was of very low safety significance (Green) because 66UC-22B maintained its functionality. The finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because FitzPatrick staff did not take appropriate corrective actions to address a safety issue in a timely manner, commensurate with its safety significance [P.1.(d)]. (Section 1R15)

Inspection Report# : [2012004](#) (*pdf*)

Significance: G Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Procedure During Removal from Service of Emergency Diesel Generator Ventilation

The inspectors identified a self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, “Procedures,” because Entergy personnel did not adequately implement procedures when removing the ventilation system for the ‘A’ emergency diesel generator (EDG) subsystem from service. Specifically, operators did not implement tagout placement instructions, which required that the affected EDGs be declared inoperable once the ventilation system was tagged out. Additionally, control room operators did not respond to the resultant ‘A’ EDG ventilation system common alarm in accordance with the alarm response procedure, which also would have led to the EDGs being declared inoperable. As a result, TS 3.8.1 was not entered in a timely manner and the TS surveillance requirement was not performed within the specified completion time. As immediate corrective action, the ‘A’ EDG subsystem was declared inoperable and the specified surveillance requirement was completed. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-02591.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the offsite electrical circuits were not verified available by operators for approximately three hours while the ‘A’ EDG subsystem was inoperable. The inspectors evaluated the finding using the Phase 1, “Initial Screening and Characterization of Findings,” worksheet in Attachment 4 to Inspection Manual Chapter (IMC) 0609, “Significance Determination Process.” The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the

inspectors determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices, because operators did not follow procedures [H.4(b)]. (Section 1R13)

Inspection Report# : [2012003](#) (*pdf*)

Significance: N/A Apr 24, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

NRC Not Notified of a Licensed Operator's Change in Medical Status

The inspectors identified a Severity Level IV NCV of 10 CFR 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, Entergy did not notify the NRC within 30 days of discovering a change in medical condition for a licensed operator. Subsequently, Entergy submitted a notification for the operator on February 15, 2012, and entered the issue into their corrective action program (CR-JAF-2012-00576). The inspectors determined that Entergy's failure to notify the NRC within 30 days of discovering the change in medical condition for the licensed operator was a performance deficiency that was within Entergy personnel's ability to foresee and correct and should have been prevented. The inspectors determined that traditional enforcement applies, as the issue had the potential to impact the NRC's ability to perform its regulatory function.

The significance of the associated performance deficiency was screened against the ROP per the guidance of IMC 0612, Appendix B. No associated ROP finding was identified and no cross-cutting aspect was assigned. This issue is similar to violation example 6.4'd.1 (a) in the NRC Enforcement Policy for a Severity Level IV violation because it involves noncompliance with medical requirements where the operator did not perform the functions of a licensed operator while having the potentially disqualifying medical condition. (Section 4OA5)

Inspection Report# : [2012301](#) (*pdf*)

Significance: N/A Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER Revision for a Condition Prohibited by TS Associated with the HPCI System

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of 10 CFR Part 50.73, "Licensee Event Report [LER] System," because a violation of Technical Specification (TS) 3.5.1.G for the condition of the high pressure coolant injection (HPCI) and reactor core isolation cooling (RCIC) systems being simultaneously inoperable was not reported to the NRC within 60 days of discovery. After this was identified by the inspectors, the issue was entered into Entergy's corrective action program (CAP) as CR-JAF-2011-04779. Entergy subsequently submitted Revision 1 to LERs 05000333/2010-005-00 and 05000333/2011-001-00.

The inspectors determined that the failure to revise LER 05000333/2010-005-00 within 60 days to include the violation of TS 3.5.1.G in accordance with 10 CFR Part 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct, and should have been prevented. Because the issue impacted the regulatory process, in that a violation of site Technical Specifications was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel did not make a report required by 10 CFR Part 50.73. In accordance with Inspection Manual Chapter (IMC) 0612, Appendix B, traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2012002](#) (*pdf*)

Significance: G Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Mode Switch in Shutdown Scram Function Inoperable in Excess of the TS Allowed Outage Time due to Personnel Error

The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 3.3.1.1, "Reactor Protection System (RPS) Instrumentation," because FitzPatrick operators did not take required action within the allowed completion time in response to an RPS relay failure. Specifically, following failure of RPS channel 'B' shutdown scram reset interlock logic relay 5A-K17B, which caused the reactor mode switch to shutdown manual scram to be disabled, action was not taken by operators to insert a half-scrum on RPS channel 'B' within one hour as required by TS 3.3.1.1 Condition C. After further evaluation of the issue, operators inserted a half scram on RPS channel 'B'. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2011-06625.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the delay in implementing the TS required actions resulted in additional accrual of more than two hours of reactor operation with the reactor mode switch to shutdown manual scram bypassed. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance (Green). This finding had a cross-cutting aspect in the area of Human Performance, decision making, because operators did not use conservative assumptions in decision making and promptly apply readily available information contained in the alarm response procedure and TS Bases to determine TS applicability for the alarm condition [H.1(b) per IMC0310]. (Section 1R13)

Inspection Report# : [2011005](#) (pdf)

Significance: G Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Ineffective Corrective Action for RCIC Steam Admission Valve Malfunction

The inspectors identified a self-revealing NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because Entergy personnel did not promptly correct the intermittent failure of reactor core isolation cooling (RCIC) steam admission valve 13MOV-131 to fully open on demand. Specifically, Entergy staff's troubleshooting performed in response to the October 29, 2010, partial valve opening was not adequate in scope to identify the cause of the intermittent failure. As corrective action, a more extensive troubleshooting effort was undertaken by Entergy staff following a second failure of the valve to fully open on January 7, 2011, which was successful at identifying and correcting the problem. The issue was entered into the CAP as CR-JAF-2011-00123.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the loose electrical connections in the 13MOV-131 motor control circuit affected the reliability of the RCIC system. Since the RCIC pump achieved rated discharge flow and pressure on both occasions that 13MOV-131 failed to fully open, the inspectors concluded that RCIC remained capable of performing its design function during the period that this condition existed. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined this finding was not a design qualification deficiency resulting in a loss of

functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance (Green). The finding had a cross-cutting aspect in the area of Human Performance, work control, because Entergy personnel did not appropriately plan the scope of 13MOV-131 troubleshooting activity by incorporating consideration of the high risk significance of the RCIC system [H.3 (a) per IMC0310]. (Section 4OA3)

Inspection Report# : [2011005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Work Planning for 'A' Reactor Recirculation Pump Replacement.

The inspectors identified a self-revealing finding that involved inadequate work planning relative to the 'A' recirculation pump replacement work during refueling outage R19 that resulted in additional unplanned collective exposure (39.168 person-rem compared to a work activity estimate of 15.831 person-rem). The actual job site conditions were not adequately evaluated by Entergy staff for interferences and the support work was not coordinated to prevent additional unnecessary exposure and did not meet the Radiation Work Permit (RWP) No. 10-0518 planned dose execution for the work activity. This inadequate evaluation lead to as-found interferences that required removal and reinstallation, and insufficient outage schedule coordination that resulted in several scaffold interferences with other outage tasks that caused avoidable scaffold rework and in unintended exposure that could have been avoided by Entergy personnel.

The finding was more than minor because it was associated with the Radiation Safety -Occupational Radiation Safety cornerstone attribute of program and process, and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, inadequate work planning resulted in unplanned, unintended collective exposure that was greater than 50 percent above the intended collective exposure and greater than five person-rem due to conditions that were reasonably within Entergy's ability to foresee and correct. The inspectors evaluated the finding using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," and determined that the finding was of very low safety significance (Green) because the finding was due to As Low As Reasonably Achievable (ALARA) work control planning and the three year rolling average collective exposure at FitzPatrick was less than 240 person-rem (146.593 person-rem for 2008-2010). The finding had a cross-cutting aspect in the area of Human Performance, work control, because Entergy's planned work activities did not adequately incorporate work site interferences or outage work coordination in the work control planning process [H.3 (b) per IMC0310]. (Section 2RS2)

Inspection Report# : [2011005](#) (pdf)

Significance: G Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Radiation Protection Procedures

The inspectors identified a self-revealing NCV of TS 5.4, "Procedures," which requires that written procedures be implemented covering the activities in the applicable procedures recommended by Regulatory Guide 1.33, including procedures for RWPs and ALARA reviews. Specifically, as of December 12, 2011, post job reviews for most of the 2010 R-19 RWPs (52 of 55) had not been completed as required by procedure EN-RP-105, "Radiological Work Permits," Revision 10. This procedure requires post job reviews to be completed within 90 days from the end of the outage. The performance deficiency could lead to repeating errors and not planning the upcoming R-20 with needed improvements. Since planning for the R-20 outage had already begun, the inspectors concluded that lessons learned in the R-19 outage RWPs may not be incorporated into the R-20 RWPs and additional, avoidable exposure could be received. Entergy staff subsequently developed a tracking schedule to complete the reviews and entered the issue into the CAP as CR-JAF-2011-04152.

The finding was more than minor because it was associated with the Radiation Safety -Occupational Radiation Safety cornerstone attribute of program and process, and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, Entergy staff did not complete RWP close out documentation to identify lessons learned and actions to reduce worker exposure in subsequent refueling outages. The inspectors evaluated the finding using IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," and determined that the finding was of very low safety significance (Green) because it did not involve: (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. The finding had a cross-cutting aspect in the area of Human Performance, work practices, because Entergy personnel did not effectively communicate expectations regarding procedural compliance [H.4(b) per IMC0310]. (Section 2RS2)

Inspection Report# : [2011005](#) (pdf)

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Mar 16, 2012

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. James A. FitzPatrick Nuclear Power Plant (FitzPatrick) personnel identified problems, entered them into the corrective action program (CAP) at a low threshold, and prioritized issues commensurate with their safety significance. In most cases, station personnel appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent-of-condition, generic issues, and previous occurrences. The inspectors also determined that Entergy personnel typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Entergy adequately identified, reviewed, and applied relevant industry operating experience to FitzPatrick operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were self-critical and thorough. Station personnel effectively identified and elevated adverse performance trends for senior site management review through use of the Entergy Trending Process.

Based on interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify indications that site personnel were unwilling to raise safety issues nor did they identify conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2012008](#) (*pdf*)

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : November 30, 2012

FitzPatrick

4Q/2012 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Install Reserve Station Service Transformers in Accordance with Procedure

The inspectors identified a self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because FitzPatrick personnel did not perform installation of replacement reserve station service transformers (RSSTs) 71T-2 and 71T-3 in accordance with written procedures. Specifically, station personnel did not remove the shorting bars from the current transformer (CT) circuits, as specified by the work instructions, which impacted trip set points for the transformer differential current protection relays. As a result, the 71T-3 differential protection circuitry actuated after the start of a major electrical load when it was not required, which caused a transformer lockout and loss of offsite power. As immediate corrective action, operators reestablished station power from the normal station service transformer via the 345 kilovolt (KV) back feed and secured the emergency diesel generators (EDGs). The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-06866.

The finding was more than minor because it affected the equipment performance attribute of the Initiating Events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding in accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." Per Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for both PWRs and BWRs," Checklist 7, "BWR Refueling Operation with RCS Level > 23'," the issue constituted a finding because, after the event, FitzPatrick did not have one operable qualified circuit between the offsite transmission network and the onsite 1E AC electrical power distribution subsystems. Also, per Checklist 7, this was not a finding requiring phase 2 or phase 3 analysis, nor did it constitute a loss of control event per Appendix G, Table 1. Therefore, the finding screened as very low safety significance (Green).

This finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy staff did not provide an accurate and up-to-date work package for installation of the RSSTs, in that the package did not include a drawing of the CT shorting terminal configured with the shorting bar removed, nor did they ensure that the work package was appropriately updated with clarifying information after workers questioned the existing instructions [H.2(c)].

Inspection Report# : [2012005](#) (*pdf*)

Significance: G Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Procedure for Installation of Reactor Water Recirculation Motor-Generator Scoop Tube Positioners

The inspectors identified a self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy staff did not provide adequate procedures for installation of a plant modification to replace the reactor water recirculation (RWR) motor-generator (MG) scoop tube positioners during the 2010 refueling outage. Specifically, excessive torque was specified for use on positioner ball joint fasteners, which damaged one of

the ball joints and resulted in subsequent binding during attempted operation. As a result, on November 11, 2010, the 'B' RWR MG scoop tube positioner bound when operators attempted to reduce pump speed, and released the following day which resulted in an unexpected power reduction of approximately 1.5 percent (40 megawatts thermal (MWt)). As immediate corrective action, control room operators reduced flow in the 'A' RWR loop to restore compliance with the TS requirement for balanced loop flow, then locked the scoop tubes for both RWR MGs pending further evaluation of the event. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2010-07782.

The finding was more than minor because it was similar to example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that it resulted in a plant transient. The finding also affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined the finding was not a loss of coolant accident or external events initiator, and did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Therefore, the inspectors determined the finding to be of very low safety significance. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because Design Engineering personnel did not ensure that accurate design documentation and procedures were available to assure successful implementation of the RWR MG scoop tube positioner modification [H.2(c)]. (Section 4OA2)

Inspection Report# : [2012003](#) (*pdf*)

Mitigating Systems

Significance: G Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure of 'A' EDG Output Breaker to Close Following Loss of Offsite Power

The inspectors identified a self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy did not establish and implement an adequate procedure for installation of a 4160 volt alternating current (VAC) circuit breaker. Specifically, FitzPatrick's procedure for 4160 VAC circuit breaker installation did not provide sufficient guidance to station personnel to preclude physical misalignment of the 'A' emergency diesel generator (EDG) output breaker which occurred during installation on September 15, 2011, and resulted in failure of the breaker to close when required following a loss of offsite power on October 5, 2012. As immediate corrective action, the 'A' EDG output breaker was racked out, re-aligned in the cubicle, and racked back in such that it was no longer misaligned and was flush with the front of the cubicle. An instrumented test of the 'A' and 'C' EDGs was performed and all breakers operated correctly. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-06868. The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the reliability of Division 1 EDG automatic operation was degraded for approximately one year due to the 'A' EDG breaker misalignment issue. Although the issue was identified while the plant was shut down, the inspectors determined that it was appropriate to evaluate the condition in accordance with the at-power SDP because the condition existed for the previous year. In accordance with Inspection Manual Chapter (IMC) 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that the finding was of very low safety significance because the finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Specifically, the 'A' EDG breaker continued to perform its safety

function as evidenced by monthly surveillance tests until the misalignment condition ultimately impacted its ability to close subsequent to October 3, 2012 testing. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick personnel did not ensure that a complete, accurate and up-to-date procedure was available for 4160 VAC circuit breaker installation. Specifically, procedure did not include steps to ensure correct alignment during breaker racking and to verify flush alignment [H.2(c)].

Inspection Report# : [2012005](#) (pdf)

Significance:  Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Corrective Action to Address Crescent Area Unit Cooler Operability

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," because FitzPatrick staff did not take timely corrective action to verify that a crescent area unit cooler was operable under postulated conditions of degraded grid voltage. Specifically, FitzPatrick staff did not schedule first time low voltage pickup testing for unit cooler 66UC-22B until after summer lake temperature had increased to the point that removing the unit cooler from service would have challenged the temperature limit for ultimate heat sink (UHS) operability. When the test was later performed, the as-found pickup voltage exceeded the maximum allowed by the procedure and required a case-specific analysis to demonstrate operability. As immediate corrective action, FitzPatrick electricians cleaned the contact assembly and retested the unit, with satisfactory results. FitzPatrick staff entered this issue into the corrective action program as condition report (CR)-JAF-2012-04443.

The finding was more than minor because it was similar to example 3.i in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that a case-specific engineering analysis was required to assure the accident analysis requirements were met. The finding also affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and determined that the finding was of very low safety significance (Green) because 66UC-22B maintained its functionality. The finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because FitzPatrick staff did not take appropriate corrective actions to address a safety issue in a timely manner, commensurate with its safety significance [P.1.(d)]. (Section 1R15)

Inspection Report# : [2012004](#) (pdf)

Significance:  Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Procedure During Removal from Service of Emergency Diesel Generator Ventilation

The inspectors identified a self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy personnel did not adequately implement procedures when removing the ventilation system for the 'A' emergency diesel generator (EDG) subsystem from service. Specifically, operators did not implement tagout placement instructions, which required that the affected EDGs be declared inoperable once the ventilation system was tagged out. Additionally, control room operators did not respond to the resultant 'A' EDG ventilation system common alarm in accordance with the alarm response procedure, which also would have led to the EDGs being declared inoperable. As a result, TS 3.8.1 was not entered in a timely manner and the TS surveillance requirement was not performed within the specified completion time. As immediate corrective action, the 'A' EDG subsystem was declared inoperable and the specified surveillance requirement was completed. The issue was entered

into the corrective action program (CAP) as condition report (CR)-JAF-2012-02591.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the offsite electrical circuits were not verified available by operators for approximately three hours while the 'A' EDG subsystem was inoperable. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to Inspection Manual Chapter (IMC) 0609, "Significance Determination Process." The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices, because operators did not follow procedures [H.4(b)]. (Section 1R13)

Inspection Report# : [2012003](#) (*pdf*)

Significance: N/A Apr 24, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

NRC Not Notified of a Licensed Operator's Change in Medical Status

The inspectors identified a Severity Level IV NCV of 10 CFR 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, Entergy did not notify the NRC within 30 days of discovering a change in medical condition for a licensed operator. Subsequently, Entergy submitted a notification for the operator on February 15, 2012, and entered the issue into their corrective action program (CR-JAF-2012-00576). The inspectors determined that Entergy's failure to notify the NRC within 30 days of discovering the change in medical condition for the licensed operator was a performance deficiency that was within Entergy personnel's ability to foresee and correct and should have been prevented. The inspectors determined that traditional enforcement applies, as the issue had the potential to impact the NRC's ability to perform its regulatory function.

The significance of the associated performance deficiency was screened against the ROP per the guidance of IMC 0612, Appendix B. No associated ROP finding was identified and no cross-cutting aspect was assigned. This issue is similar to violation example 6.4'd.1 (a) in the NRC Enforcement Policy for a Severity Level IV violation because it involves noncompliance with medical requirements where the operator did not perform the functions of a licensed operator while having the potentially disqualifying medical condition. (Section 4OA5)

Inspection Report# : [2012301](#) (*pdf*)

Significance: N/A Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER Revision for a Condition Prohibited by TS Associated with the HPCI System

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of 10 CFR Part 50.73, "Licensee Event Report [LER] System," because a violation of Technical Specification (TS) 3.5.1.G for the condition of the high pressure coolant injection (HPCI) and reactor core isolation cooling (RCIC) systems being simultaneously inoperable was not reported to the NRC within 60 days of discovery. After this was identified by the inspectors, the issue was entered into Entergy's corrective action program (CAP) as CR-JAF-2011-04779. Entergy subsequently submitted Revision 1 to LERs 05000333/2010-005-00 and 05000333/2011-001-00.

The inspectors determined that the failure to revise LER 05000333/2010-005-00 within 60 days to include the violation of TS 3.5.1.G in accordance with 10 CFR Part 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct, and should have been prevented. Because the issue impacted the regulatory process, in that a violation of site Technical Specifications was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined the violation was a SL IV violation because Entergy personnel did not make a report required by 10 CFR Part 50.73. In accordance with IMC 0612, Appendix B, there was no underlying ROP performance issue that was more than minor and therefore the issue was not assigned a cross-cutting aspect.

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Mar 16, 2012

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. James A. FitzPatrick Nuclear Power Plant (FitzPatrick) personnel identified problems, entered them into the corrective action program (CAP) at a low threshold, and prioritized issues commensurate with their safety significance. In most cases, station personnel appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent-of-condition, generic issues, and previous occurrences. The inspectors also determined that Entergy personnel typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Entergy adequately identified, reviewed, and applied relevant industry operating experience to FitzPatrick operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were self-critical and thorough. Station personnel effectively identified and elevated adverse performance trends for senior site management review through use of the Entergy Trending Process.

Based on interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify indications that site personnel were unwilling to raise safety issues nor did they identify conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2012008](#) (*pdf*)

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : February 28, 2013

FitzPatrick

1Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Install Reserve Station Service Transformers in Accordance with Procedure

The inspectors identified a self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because FitzPatrick personnel did not perform installation of replacement reserve station service transformers (RSSTs) 71T-2 and 71T-3 in accordance with written procedures. Specifically, station personnel did not remove the shorting bars from the current transformer (CT) circuits, as specified by the work instructions, which impacted trip set points for the transformer differential current protection relays. As a result, the 71T-3 differential protection circuitry actuated after the start of a major electrical load when it was not required, which caused a transformer lockout and loss of offsite power. As immediate corrective action, operators reestablished station power from the normal station service transformer via the 345 kilovolt (KV) back feed and secured the emergency diesel generators (EDGs). The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-06866.

The finding was more than minor because it affected the equipment performance attribute of the Initiating Events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding in accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." Per Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for both PWRs and BWRs," Checklist 7, "BWR Refueling Operation with RCS Level > 23'," the issue constituted a finding because, after the event, FitzPatrick did not have one operable qualified circuit between the offsite transmission network and the onsite 1E AC electrical power distribution subsystems. Also, per Checklist 7, this was not a finding requiring phase 2 or phase 3 analysis, nor did it constitute a loss of control event per Appendix G, Table 1. Therefore, the finding screened as very low safety significance (Green).

This finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy staff did not provide an accurate and up-to-date work package for installation of the RSSTs, in that the package did not include a drawing of the CT shorting terminal configured with the shorting bar removed, nor did they ensure that the work package was appropriately updated with clarifying information after workers questioned the existing instructions [H.2(c)].

Inspection Report# : [2012005](#) (*pdf*)

Significance: G Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Procedure for Installation of Reactor Water Recirculation Motor-Generator Scoop Tube Positioners

The inspectors identified a self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy staff did not provide adequate procedures for installation of a plant modification to replace the reactor water recirculation (RWR) motor-generator (MG) scoop tube positioners during the 2010 refueling outage. Specifically, excessive torque was specified for use on positioner ball joint fasteners, which damaged one of the ball joints and resulted in subsequent binding during attempted operation. As a result, on November 11, 2010, the 'B' RWR MG scoop tube positioner bound when operators attempted to reduce pump speed, and released the following day which resulted in an unexpected power reduction of approximately 1.5 percent (40 megawatts thermal (MWt)). As immediate corrective action, control room operators reduced flow in the 'A' RWR loop to restore compliance with the TS requirement for balanced loop flow, then locked the scoop tubes for both RWR MGs pending further evaluation of the event. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2010-07782.

The finding was more than minor because it was similar to example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that it resulted in a plant transient. The finding also affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization," worksheet in Attachment 4 to IMC 0609, "Significance Determination Process." The inspectors determined the finding was not a loss of coolant accident or external events initiator, and did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Therefore, the inspectors determined the finding to be of very low safety significance. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because Design Engineering personnel did not ensure that accurate design documentation and procedures were available to assure successful implementation of the RWR MG scoop tube positioner modification [H.2(c)]. (Section 4OA2)

Inspection Report# : [2012003](#) (*pdf*)

Mitigating Systems

Significance: 6 Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Licensee Event Report for a Condition That Could Have Prevented Fulfillment of the High-Pressure Coolant Injection System Safety Function

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.73, "Licensee Event Report (LER) System," because failure of an isolation valve in the high-pressure coolant injection (HPCI) system torus suction line to fully open on demand caused the automatic suction swap function to be inoperable, but this condition was not reported to the NRC as a condition that could have prevented fulfillment of a safety function per 10 CFR 50.73(a)(v) within 60 days of when it should reasonably have been discovered. Specifically, while this condition existed, an automatic suction swap from the condensate storage tanks (CSTs) to the torus would not have gone to completion, but rather would have stopped with both suction paths open. Depending on whether or not HPCI was running at the time, this would either result in air entrainment in the HPCI pump suction, causing a loss of HPCI, or an increase in suppression pool level due to drainage from the CSTs. However, this condition was not reported to the NRC as a condition that could have prevented fulfillment of a safety function per 10 CFR 50.73(a)(v) within 60 days of when it should reasonably have been discovered. This issue was entered into the corrective action program as condition report (CR)-JAF-2013-01768.

The inspectors determined that the failure to submit an LER within 60 days in accordance with 10 CFR 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.73 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Licensee Event Report for Condition Prohibited by Technical Specification 3.0.4

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.73, "Licensee Event Report (LER) System," because a violation of technical specification (TS) 3.0.4 for a reactor mode change being made from Mode 4 to Mode 2 without satisfying the TS required conditions for alignment of the containment air dilution and standby gas treatment (SGT) systems in Mode 2 was not reported to the NRC within 60 days of when it should reasonably have been discovered. Specifically, in Modes 1, 2, and 3, TS surveillance requirement 3.6.1.3.1 allows the 20-inch and 24-inch primary containment vent and purge valves to be open for inerting, deinerting, pressure control, or other reasons provided that valve 27MOV-120 in the full flow line to the SGT system is closed. This is to ensure that there would be no damage to the SGT filters if a loss-of-coolant accident were to occur with the vent and purge valves open. However, on November 24, 2012, operators transitioned the reactor from Mode 4 to Mode 2 while the 20-inch and 24-inch containment vent and purge valves and valve 27MOV-120 were open. This condition was not reported to the NRC within 60 days of when it should reasonably have been discovered. As immediate corrective action, FitzPatrick staff entered the issue into the corrective action program as condition report (CR)-JAF-2013-01097.

The inspectors determined that the failure to submit an LER within 60 days in accordance with 10 CFR 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process in that a violation of site TSs was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.73 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Obtain NRC Staff Review and Approval Prior to Changing the Technical Specification Definition

of a Core Quadrant

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.59, “Changes, Tests, and Experiments,” because Entergy personnel implemented a change to the technical specification (TS) definition of core quadrant without prior review and approval by the NRC staff in accordance with 10 CFR 50.59(c)(1)(i). Specifically, Entergy staff changed the definition of core quadrant in Revision 5 of reactor analyst procedure RAP-7.1.04C, “Neutron Instrumentation Monitoring During In-Core Fuel Handling,” which allowed operators to interpret what constitute core quadrant boundaries such that core alterations could be performed anywhere in the core provided any three source range (neutron) monitors (SRMs) were operable. As immediate corrective action to the task interface agreement final response, FitzPatrick staff withdrew RAP-7.1.04C pending revision of the core quadrant definition. The inspectors verified that TS 3.3.1.2.2 had been satisfied during all core alterations that were performed during the 2010 and 2012 refueling outages using the standard definition of a core quadrant. Entergy staff entered this issue into the corrective action program as condition report (CR)-HQN-2013-00034.

The inspectors determined that Entergy staff’s implementation of a redefinition of core quadrant prior to its review and approval by the NRC staff as specified in 10 CFR 50.59(c)(1)(i) was a performance deficiency that was reasonably within Entergy staff’s ability to foresee and correct. Because this was a violation of 10 CFR 50.59, it was considered to be a violation that potentially impedes or impacts the regulatory process. Therefore, this violation was characterized using the traditional enforcement process. The violation was determined to be more than minor in accordance with the NRC Enforcement Manual, Section 7.3.E.6, because there was a reasonable likelihood that the change to the definition of what constituted a “core quadrant boundary” would require Commission review and approval prior to implementation. Additionally, the inspectors noted that in accordance with Inspection Manual Chapter (IMC) 0612, Appendix B, “Issue Screening,” the underlying performance deficiency would screen as more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, potentially inadequate SRM coverage during refueling operations could affect the TS bases function to provide early indication of unexpected subcritical multiplication that could be indicative of an approach to criticality. NRC Enforcement Manual Section 7.3 provides guidance to assess 10 CFR 50.59 violations through the significance determination process (SDP). In this case, the inspectors determined the violation could be evaluated using the SDP in accordance with IMC 0609 Appendix G, “Shutdown Operations Significance Determination Process,” Checklist 7, “BWR Refueling Operation with RCS Level Greater Than 23 Feet.” The finding affected the reactivity guidelines attribute that assumes existing core alteration TS are being met. Since this attribute does not require quantitative assessment, the finding was screened as Green in accordance with Section 3.3, “Mitigation Capability.” In accordance with the NRC Enforcement Policy, Section 6.1.d.2, this violation was categorized as Severity Level IV because the issue was evaluated by the SDP as having very low safety significance (Green). The finding did not have a cross-cutting aspect because the performance deficiency did not occur within the past 3 years and, therefore, was not reflective of present performance.

Inspection Report# : [2013002](#) (pdf)

Significance: G Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure of ‘A’ EDG Output Breaker to Close Following Loss of Offsite Power

The inspectors identified a self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, “Procedures,” because Entergy did not establish and implement an adequate procedure for installation of a 4160 volt alternating current (VAC) circuit breaker. Specifically, FitzPatrick’s procedure for 4160 VAC circuit breaker installation did not provide sufficient guidance to station personnel to preclude physical misalignment of the ‘A’ emergency diesel generator (EDG) output breaker which occurred during installation on September 15, 2011, and resulted in failure of the breaker to close when required

following a loss of offsite power on October 5, 2012. As immediate corrective action, the 'A' EDG output breaker was racked out, re-aligned in the cubicle, and racked back in such that it was no longer misaligned and was flush with the front of the cubicle. An instrumented test of the 'A' and 'C' EDGs was performed and all breakers operated correctly. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-06868. The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the reliability of Division 1 EDG automatic operation was degraded for approximately one year due to the 'A' EDG breaker misalignment issue. Although the issue was identified while the plant was shut down, the inspectors determined that it was appropriate to evaluate the condition in accordance with the at-power SDP because the condition existed for the previous year. In accordance with Inspection Manual Chapter (IMC) 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that the finding was of very low safety significance because the finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Specifically, the 'A' EDG breaker continued to perform its safety function as evidenced by monthly surveillance tests until the misalignment condition ultimately impacted its ability to close subsequent to October 3, 2012 testing. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick personnel did not ensure that a complete, accurate and up-to-date procedure was available for 4160 VAC circuit breaker installation. Specifically, procedure did not include steps to ensure correct alignment during breaker racking and to verify flush alignment [H.2(c)].

Inspection Report# : [2012005](#) (*pdf*)

Significance:  Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Corrective Action to Address Crescent Area Unit Cooler Operability

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," because FitzPatrick staff did not take timely corrective action to verify that a crescent area unit cooler was operable under postulated conditions of degraded grid voltage. Specifically, FitzPatrick staff did not schedule first time low voltage pickup testing for unit cooler 66UC-22B until after summer lake temperature had increased to the point that removing the unit cooler from service would have challenged the temperature limit for ultimate heat sink (UHS) operability. When the test was later performed, the as-found pickup voltage exceeded the maximum allowed by the procedure and required a case-specific analysis to demonstrate operability. As immediate corrective action, FitzPatrick electricians cleaned the contact assembly and retested the unit, with satisfactory results. FitzPatrick staff entered this issue into the corrective action program as condition report (CR)-JAF-2012-04443.

The finding was more than minor because it was similar to example 3.i in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that a case-specific engineering analysis was required to assure the accident analysis requirements were met. The finding also affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated

the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and determined that the finding was of very low safety significance (Green) because 66UC-22B maintained its functionality. The finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because FitzPatrick staff did not take appropriate corrective actions to address a safety issue in a timely manner, commensurate with its safety significance [P.1.(d)]. (Section 1R15)

Inspection Report# : [2012004](#) (*pdf*)

Significance: G Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Procedure During Removal from Service of Emergency Diesel Generator Ventilation

The inspectors identified a self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy personnel did not adequately implement procedures when removing the ventilation system for the 'A' emergency diesel generator (EDG) subsystem from service. Specifically, operators did not implement tagout placement instructions, which required that the affected EDGs be declared inoperable once the ventilation system was tagged out. Additionally, control room operators did not respond to the resultant 'A' EDG ventilation system common alarm in accordance with the alarm response procedure, which also would have led to the EDGs being declared inoperable. As a result, TS 3.8.1 was not entered in a timely manner and the TS surveillance requirement was not performed within the specified completion time. As immediate corrective action, the 'A' EDG subsystem was declared inoperable and the specified surveillance requirement was completed. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-02591.

The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the offsite electrical circuits were not verified available by operators for approximately three hours while the 'A' EDG subsystem was inoperable. The inspectors evaluated the finding using the Phase 1, "Initial Screening and Characterization of Findings," worksheet in Attachment 4 to Inspection Manual Chapter (IMC) 0609, "Significance Determination Process." The inspectors determined this finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Therefore, the inspectors determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices, because operators did not follow procedures [H.4(b)]. (Section 1R13)

Inspection Report# : [2012003](#) (*pdf*)

Significance: N/A Apr 24, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

NRC Not Notified of a Licensed Operator's Change in Medical Status

The inspectors identified a Severity Level IV NCV of 10 CFR 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, Entergy did not notify the NRC within 30 days of discovering a change in medical condition for a licensed operator. Subsequently, Entergy submitted a notification for the operator on February 15, 2012, and entered the issue into their corrective action program (CR-JAF-2012-00576). The inspectors determined that Entergy's failure to notify the NRC within 30 days of discovering the change in medical condition for the licensed operator was a performance deficiency that was within Entergy personnel's ability to foresee and correct and should have been prevented. The inspectors determined that traditional enforcement applies, as the issue had the potential to impact the NRC's ability to perform its regulatory function.

The significance of the associated performance deficiency was screened against the ROP per the guidance of IMC 0612, Appendix B. No associated ROP finding was identified and no cross-cutting aspect was assigned. This issue is similar to violation example 6.4'd.1 (a) in the NRC Enforcement Policy for a Severity Level IV violation because it involves noncompliance with medical requirements where the operator did not perform the functions of a licensed operator while having the potentially disqualifying medical condition. (Section 4OA5)

Inspection Report# : [2012301](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : June 04, 2013

FitzPatrick 2Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Install Reserve Station Service Transformers in Accordance with Procedure

The inspectors identified a self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because FitzPatrick personnel did not perform installation of replacement reserve station service transformers (RSSTs) 71T-2 and 71T-3 in accordance with written procedures. Specifically, station personnel did not remove the shorting bars from the current transformer (CT) circuits, as specified by the work instructions, which impacted trip set points for the transformer differential current protection relays. As a result, the 71T-3 differential protection circuitry actuated after the start of a major electrical load when it was not required, which caused a transformer lockout and loss of offsite power. As immediate corrective action, operators reestablished station power from the normal station service transformer via the 345 kilovolt (KV) back feed and secured the emergency diesel generators (EDGs). The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-06866.

The finding was more than minor because it affected the equipment performance attribute of the Initiating Events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding in accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." Per Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for both PWRs and BWRs," Checklist 7, "BWR Refueling Operation with RCS Level > 23'," the issue constituted a finding because, after the event, FitzPatrick did not have one operable qualified circuit between the offsite transmission network and the onsite 1E AC electrical power distribution subsystems. Also, per Checklist 7, this was not a finding requiring phase 2 or phase 3 analysis, nor did it constitute a loss of control event per Appendix G, Table 1. Therefore, the finding screened as very low safety significance (Green).

This finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy staff did not provide an accurate and up-to-date work package for installation of the RSSTs, in that the package did not include a drawing of the CT shorting terminal configured with the shorting bar removed, nor did they ensure that the work package was appropriately updated with clarifying information after workers questioned the existing instructions [H.2(c)].

Inspection Report# : [2012005](#) (*pdf*)

Mitigating Systems

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Technical Specification Actions for Inoperable Control Rod Not Performed Within the Technical Specification Allowed Completion

The inspectors identified a non-cited violation of technical specification (TS) 3.1.3, “Control Rod Operability,” because Entergy operators did not take the required actions within the allowed completion time in response to indication that the scram capability of a control rod was indeterminate. Specifically, when available information concerning the scram solenoid pilot valves (SSPVs) required control rod 30-11 to be declared inoperable, operators did not declare the control rod inoperable, did not fully insert the control rod within 3 hours, and did not disarm the associated control rod drive within 4 hours as required by TS 3.1.3.C. Entergy’s corrective actions included fully inserting and electrically disarming control rod 30-11, replacing the SSPVs, revising the instructions to operators, briefing operators on this issue, and initiating a condition report.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, operators did not fully insert and electrically disarm control rod 30-11 within the TS allowed completion time when the scram capability of the control rod was indeterminate and, therefore, required to be declared inoperable. In accordance with Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process for Findings At Power,” the finding was of very low safety significance (Green) because it did not affect multiple automatic reactor shutdown functions, did not involve an unintentional positive reactivity addition, and did not result in inability to control changes in reactivity during crew operations. The finding had a cross-cutting aspect in the area of Human Performance, Decision Making, because, given industry operating experience that cessation of the SSPV buzzing sound was a possible indication of a condition that would prevent the SSPV from performing its safety function. Entergy staff did not communicate to on-shift operations department personnel the need to promptly declare control rod 30-11 inoperable if this condition were to occur [H.1(c)].

Inspection Report# : [2013003](#) (pdf)

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: FIN Finding

Inadequate Corrective Action for Decay Heat Removal System Degradation Results in Loss of Decay Heat Removal During Refueling Outage 20

A self-revealing finding (FIN) was identified for a loss of decay heat removal (DHR) during refueling outage 20 (R20) that was the result of inadequately remediated DHR system degradation. Specifically, prior to using the system during R20, Entergy did not clean scale buildup in the DHR secondary cooling loop heat exchangers (HXs) causing low secondary system pressure, and Entergy did not address the resultant reduction in margin to the primary cooling loop pump automatic shutdown on low primary-to-secondary differential pressure. As a result, a spurious automatic DHR system shutdown occurred while it was functioning as the alternate method of DHR in place of residual heat removal (RHR) shutdown cooling. Entergy’s corrective actions included restarting DHR and initiating condition report CR-JAF-2012-06934. Entergy also initiated actions to evaluate corrective measures such as modifying the differential pressure trip, adding secondary loop water chemistry treatment, and cleaning of the HXs.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, there was an unplanned shutdown of the DHR system for about 50 minutes when it was providing the

shutdown cooling function. The inspectors determined the significance of the finding using Inspection Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process." Per Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for both PWRs [pressurized water reactors] and BWRs [boiling water reactors]," Checklist 7, "BWR Refueling Operation with RCS Level > 23'," this finding impacted checklist item I.C because at the time of the event, the DHR system was functioning as the alternate method of DHR in place of RHR shutdown cooling. The finding was determined to be of very low safety significance (Green) because the finding did not require a quantitative assessment as described in Checklist 7 of Attachment 1 to Appendix G, because checklist item I.C. is not listed as requiring phase 2 or 3 analysis, and the finding did not constitute a loss of control event per Appendix G, Table 1. The inspectors determined that the finding had a cross-cutting aspect in the Problem Identification and Resolution area, Corrective Action Program component, because Entergy staff did not take appropriate corrective actions to address the adverse trend in DHR system performance [P.1(d)].

Inspection Report# : [2013003](#) (*pdf*)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Licensee Event Report for a Condition That Could Have Prevented Fulfillment of the High-Pressure Coolant Injection System Safety Function

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.73, "Licensee Event Report (LER) System," because failure of an isolation valve in the high-pressure coolant injection (HPCI) system torus suction line to fully open on demand caused the automatic suction swap function to be inoperable, but this condition was not reported to the NRC as a condition that could have prevented fulfillment of a safety function per 10 CFR 50.73(a)(v) within 60 days of when it should reasonably have been discovered. Specifically, while this condition existed, an automatic suction swap from the condensate storage tanks (CSTs) to the torus would not have gone to completion, but rather would have stopped with both suction paths open. Depending on whether or not HPCI was running at the time, this would either result in air entrainment in the HPCI pump suction, causing a loss of HPCI, or an increase in suppression pool level due to drainage from the CSTs. However, this condition was not reported to the NRC as a condition that could have prevented fulfillment of a safety function per 10 CFR 50.73(a)(v) within 60 days of when it should reasonably have been discovered. This issue was entered into the corrective action program as condition report (CR)-JAF-2013-01768.

The inspectors determined that the failure to submit an LER within 60 days in accordance with 10 CFR 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.73 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013002](#) (*pdf*)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Licensee Event Report for Condition Prohibited by Technical Specification 3.0.4

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.73, "Licensee Event Report (LER) System," because a violation of technical specification (TS) 3.0.4 for a

reactor mode change being made from Mode 4 to Mode 2 without satisfying the TS required conditions for alignment of the containment air dilution and standby gas treatment (SGT) systems in Mode 2 was not reported to the NRC within 60 days of when it should reasonably have been discovered. Specifically, in Modes 1, 2, and 3, TS surveillance requirement 3.6.1.3.1 allows the 20-inch and 24-inch primary containment vent and purge valves to be open for inerting, deinerting, pressure control, or other reasons provided that valve 27MOV-120 in the full flow line to the SGT system is closed. This is to ensure that there would be no damage to the SGT filters if a loss-of-coolant accident were to occur with the vent and purge valves open. However, on November 24, 2012, operators transitioned the reactor from Mode 4 to Mode 2 while the 20-inch and 24-inch containment vent and purge valves and valve 27MOV-120 were open. This condition was not reported to the NRC within 60 days of when it should reasonably have been discovered. As immediate corrective action, FitzPatrick staff entered the issue into the corrective action program as condition report (CR)-JAF-2013-01097.

The inspectors determined that the failure to submit an LER within 60 days in accordance with 10 CFR 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process in that a violation of site TSs was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.73 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013002](#) (pdf)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Obtain NRC Staff Review and Approval Prior to Changing the Technical Specification Definition of a Core Quadrant

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.59, "Changes, Tests, and Experiments," because Entergy personnel implemented a change to the technical specification (TS) definition of core quadrant without prior review and approval by the NRC staff in accordance with 10 CFR 50.59(c)(1)(i). Specifically, Entergy staff changed the definition of core quadrant in Revision 5 of reactor analyst procedure RAP-7.1.04C, "Neutron Instrumentation Monitoring During In-Core Fuel Handling," which allowed operators to interpret what constitute core quadrant boundaries such that core alterations could be performed anywhere in the core provided any three source range (neutron) monitors (SRMs) were operable. As immediate corrective action to the task interface agreement final response, FitzPatrick staff withdrew RAP-7.1.04C pending revision of the core quadrant definition. The inspectors verified that TS 3.3.1.2.2 had been satisfied during all core alterations that were performed during the 2010 and 2012 refueling outages using the standard definition of a core quadrant. Entergy staff entered this issue into the corrective action program as condition report (CR)-HQN-2013-00034.

The inspectors determined that Entergy staff's implementation of a redefinition of core quadrant prior to its review and approval by the NRC staff as specified in 10 CFR 50.59(c)(1)(i) was a performance deficiency that was reasonably within Entergy staff's ability to foresee and correct. Because this was a violation of 10 CFR 50.59, it was considered to be a violation that potentially impedes or impacts the regulatory process. Therefore, this violation was characterized using the traditional enforcement process. The violation was determined to be more than minor in accordance with the NRC Enforcement Manual, Section 7.3.E.6, because there was a reasonable likelihood that the change to the definition of what constituted a "core quadrant boundary" would require Commission review and approval prior to implementation. Additionally, the inspectors noted that in accordance with Inspection Manual

Chapter (IMC) 0612, Appendix B, "Issue Screening," the underlying performance deficiency would screen as more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, potentially inadequate SRM coverage during refueling operations could affect the TS bases function to provide early indication of unexpected subcritical multiplication that could be indicative of an approach to criticality. NRC Enforcement Manual Section 7.3 provides guidance to assess 10 CFR 50.59 violations through the significance determination process (SDP). In this case, the inspectors determined the violation could be evaluated using the SDP in accordance with IMC 0609 Appendix G, "Shutdown Operations Significance Determination Process," Checklist 7, "BWR Refueling Operation with RCS Level Greater Than 23 Feet." The finding affected the reactivity guidelines attribute that assumes existing core alteration TS are being met. Since this attribute does not require quantitative assessment, the finding was screened as Green in accordance with Section 3.3, "Mitigation Capability." In accordance with the NRC Enforcement Policy, Section 6.1.d.2, this violation was categorized as Severity Level IV because the issue was evaluated by the SDP as having very low safety significance (Green). The finding did not have a cross-cutting aspect because the performance deficiency did not occur within the past 3 years and, therefore, was not reflective of present performance.

Inspection Report# : [2013002](#) (*pdf*)

Significance: G Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure of 'A' EDG Output Breaker to Close Following Loss of Offsite Power

The inspectors identified a self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy did not establish and implement an adequate procedure for installation of a 4160 volt alternating current (VAC) circuit breaker. Specifically, FitzPatrick's procedure for 4160 VAC circuit breaker installation did not provide sufficient guidance to station personnel to preclude physical misalignment of the 'A' emergency diesel generator (EDG) output breaker which occurred during installation on September 15, 2011, and resulted in failure of the breaker to close when required following a loss of offsite power on October 5, 2012. As immediate corrective action, the 'A' EDG output breaker was racked out, re-aligned in the cubicle, and racked back in such that it was no longer misaligned and was flush with the front of the cubicle. An instrumented test of the 'A' and 'C' EDGs was performed and all breakers operated correctly. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-06868. The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the reliability of Division 1 EDG automatic operation was degraded for approximately one year due to the 'A' EDG breaker misalignment issue. Although the issue was identified while the plant was shut down, the inspectors determined that it was appropriate to evaluate the condition in accordance with the at-power SDP because the condition existed for the previous year. In accordance with Inspection Manual Chapter (IMC) 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that the finding was of very low safety significance because the finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Specifically, the 'A' EDG breaker continued to perform its safety function as evidenced by monthly surveillance tests until the misalignment condition ultimately impacted its ability to close subsequent to October 3, 2012 testing. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick personnel did not ensure that a complete, accurate and up-to-date

procedure was available for 4160 VAC circuit breaker installation. Specifically, procedure did not include steps to ensure correct alignment during breaker racking and to verify flush alignment [H.2(c)].

Inspection Report# : [2012005](#) (*pdf*)

Significance:  Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Corrective Action to Address Crescent Area Unit Cooler Operability

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," because FitzPatrick staff did not take timely corrective action to verify that a crescent area unit cooler was operable under postulated conditions of degraded grid voltage. Specifically, FitzPatrick staff did not schedule first time low voltage pickup testing for unit cooler 66UC-22B until after summer lake temperature had increased to the point that removing the unit cooler from service would have challenged the temperature limit for ultimate heat sink (UHS) operability. When the test was later performed, the as-found pickup voltage exceeded the maximum allowed by the procedure and required a case-specific analysis to demonstrate operability. As immediate corrective action, FitzPatrick electricians cleaned the contact assembly and retested the unit, with satisfactory results. FitzPatrick staff entered this issue into the corrective action program as condition report (CR)-JAF-2012-04443.

The finding was more than minor because it was similar to example 3.i in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that a case-specific engineering analysis was required to assure the accident analysis requirements were met. The finding also affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and determined that the finding was of very low safety significance (Green) because 66UC-22B maintained its functionality. The finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because FitzPatrick staff did not take appropriate corrective actions to address a safety issue in a timely manner, commensurate with its safety significance [P.1.(d)].

(Section 1R15)

Inspection Report# : [2012004](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : September 03, 2013

FitzPatrick

3Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Reactor Water Recirculation Digital Flow Control Modification Post-Maintenance Test Procedure Results in Unexpected Power Increase

The inspectors identified a Green self-revealing non-cited violation of Technical Specification (TS) 5.4, "Procedures," because Entergy Nuclear Northeast (Entergy) staff did not adequately preplan the implementation of a plant modification to install a digital reactor water recirculation (RWR) flow control system during the 2012 refueling outage. Specifically, post-maintenance testing (PMT) failed to identify that a portion of the runback logic was incorrectly programmed. As a result, the RWR system was restored to operation without identifying the error. On November 8, 2012, during power ascension activities following a subsequent forced outage, the 'A' RWR pump demand signal increased from minimum flow (approximately 30 percent) to approximately 44 percent with no operator action when feedwater flow increased above 20 percent. This resulted in an unexpected power increase of approximately 1.4 percent (37 megawatts thermal. As immediate corrective action, control room operators reduced flow in the 'A' RWR loop to restore it to pre-transient conditions, locked the scoop tubes for both RWR motor-generators, and placed the power ascension on hold pending further evaluation of the event. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-08042. The issue of inadequate PMT was subsequently entered into the CAP as CR-JAF-2013-05326.

The finding was more than minor because it was similar to Example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that it resulted in a plant transient. In addition, the finding adversely affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined this finding was of very low significance (Green) because the performance deficiency did not cause a reactor trip or the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy did not ensure that the PMT acceptance criteria specified in the engineering change package were clearly translated into PMT testing work packages to verify successful implementation of the digital RWR flow control modification [H.2(c)].

Inspection Report# : [2013004](#) (*pdf*)

Significance: G Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Install Reserve Station Service Transformers in Accordance with Procedure

The inspectors identified a self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because FitzPatrick personnel did not perform installation of replacement reserve station service transformers (RSSTs) 71T-2 and 71T-3 in accordance with written procedures. Specifically, station personnel did not remove

the shorting bars from the current transformer (CT) circuits, as specified by the work instructions, which impacted trip set points for the transformer differential current protection relays. As a result, the 71T-3 differential protection circuitry actuated after the start of a major electrical load when it was not required, which caused a transformer lockout and loss of offsite power. As immediate corrective action, operators reestablished station power from the normal station service transformer via the 345 kilovolt (KV) back feed and secured the emergency diesel generators (EDGs). The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-06866.

The finding was more than minor because it affected the equipment performance attribute of the Initiating Events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding in accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." Per Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for both PWRs and BWRs," Checklist 7, "BWR Refueling Operation with RCS Level > 23'," the issue constituted a finding because, after the event, FitzPatrick did not have one operable qualified circuit between the offsite transmission network and the onsite 1E AC electrical power distribution subsystems. Also, per Checklist 7, this was not a finding requiring phase 2 or phase 3 analysis, nor did it constitute a loss of control event per Appendix G, Table 1. Therefore, the finding screened as very low safety significance (Green).

This finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy staff did not provide an accurate and up-to-date work package for installation of the RSSTs, in that the package did not include a drawing of the CT shorting terminal configured with the shorting bar removed, nor did they ensure that the work package was appropriately updated with clarifying information after workers questioned the existing instructions [H.2(c)].

Inspection Report# : [2012005](#) (*pdf*)

Mitigating Systems

Significance:  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Technical Specification Actions for Inoperable Control Rod Not Performed Within the Technical Specification Allowed Completion

The inspectors identified a non-cited violation of technical specification (TS) 3.1.3, "Control Rod Operability," because Entergy operators did not take the required actions within the allowed completion time in response to indication that the scram capability of a control rod was indeterminate. Specifically, when available information concerning the scram solenoid pilot valves (SSPVs) required control rod 30-11 to be declared inoperable, operators did not declare the control rod inoperable, did not fully insert the control rod within 3 hours, and did not disarm the associated control rod drive within 4 hours as required by TS 3.1.3.C. Entergy's corrective actions included fully inserting and electrically disarming control rod 30-11, replacing the SSPVs, revising the instructions to operators, briefing operators on this issue, and initiating a condition report.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and

capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, operators did not fully insert and electrically disarm control rod 30-11 within the TS allowed completion time when the scram capability of the control rod was indeterminate and, therefore, required to be declared inoperable. In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At Power," the finding was of very low safety significance (Green) because it did not affect multiple automatic reactor shutdown functions, did not involve an unintentional positive reactivity addition, and did not result in inability to control changes in reactivity during crew operations. The finding had a cross-cutting aspect in the area of Human Performance, Decision Making, because, given industry operating experience that cessation of the SSPV buzzing sound was a possible indication of a condition that would prevent the SSPV from performing its safety function. Entergy staff did not communicate to on-shift operations department personnel the need to promptly declare control rod 30-11 inoperable if this condition were to occur [H.1(c)].

Inspection Report# : [2013003](#) (pdf)

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: FIN Finding

Inadequate Corrective Action for Decay Heat Removal System Degradation Results in Loss of Decay Heat Removal During Refueling Outage 20

A self-revealing finding (FIN) was identified for a loss of decay heat removal (DHR) during refueling outage 20 (R20) that was the result of inadequately remediated DHR system degradation. Specifically, prior to using the system during R20, Entergy did not clean scale buildup in the DHR secondary cooling loop heat exchangers (HXs) causing low secondary system pressure, and Entergy did not address the resultant reduction in margin to the primary cooling loop pump automatic shutdown on low primary-to-secondary differential pressure. As a result, a spurious automatic DHR system shutdown occurred while it was functioning as the alternate method of DHR in place of residual heat removal (RHR) shutdown cooling. Entergy's corrective actions included restarting DHR and initiating condition report CR-JAF-2012-06934. Entergy also initiated actions to evaluate corrective measures such as modifying the differential pressure trip, adding secondary loop water chemistry treatment, and cleaning of the HXs.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, there was an unplanned shutdown of the DHR system for about 50 minutes when it was providing the shutdown cooling function. The inspectors determined the significance of the finding using Inspection Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process." Per Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for both PWRs [pressurized water reactors] and BWRs [boiling water reactors]," Checklist 7, "BWR Refueling Operation with RCS Level > 23'," this finding impacted checklist item I.C because at the time of the event, the DHR system was functioning as the alternate method of DHR in place of RHR shutdown cooling. The finding was determined to be of very low safety significance (Green) because the finding did not require a quantitative assessment as described in Checklist 7 of Attachment 1 to Appendix G, because checklist item I.C. is not listed as requiring phase 2 or 3 analysis, and the finding did not constitute a loss of control event per Appendix G, Table 1. The inspectors determined that the finding had a cross-cutting aspect in the Problem Identification and Resolution area, Corrective Action Program component, because Entergy staff did not take appropriate corrective actions to address the adverse trend in DHR system performance [P.1(d)].

Inspection Report# : [2013003](#) (pdf)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Licensee Event Report for a Condition That Could Have Prevented Fulfillment of the High-Pressure Coolant Injection System Safety Function

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.73, "Licensee Event Report (LER) System," because failure of an isolation valve in the high-pressure coolant injection (HPCI) system torus suction line to fully open on demand caused the automatic suction swap function to be inoperable, but this condition was not reported to the NRC as a condition that could have prevented fulfillment of a safety function per 10 CFR 50.73(a)(v) within 60 days of when it should reasonably have been discovered. Specifically, while this condition existed, an automatic suction swap from the condensate storage tanks (CSTs) to the torus would not have gone to completion, but rather would have stopped with both suction paths open. Depending on whether or not HPCI was running at the time, this would either result in air entrainment in the HPCI pump suction, causing a loss of HPCI, or an increase in suppression pool level due to drainage from the CSTs. However, this condition was not reported to the NRC as a condition that could have prevented fulfillment of a safety function per 10 CFR 50.73(a)(v) within 60 days of when it should reasonably have been discovered. This issue was entered into the corrective action program as condition report (CR)-JAF-2013-01768.

The inspectors determined that the failure to submit an LER within 60 days in accordance with 10 CFR 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.73 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013002](#) (*pdf*)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Licensee Event Report for Condition Prohibited by Technical Specification 3.0.4

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.73, "Licensee Event Report (LER) System," because a violation of technical specification (TS) 3.0.4 for a reactor mode change being made from Mode 4 to Mode 2 without satisfying the TS required conditions for alignment of the containment air dilution and standby gas treatment (SGT) systems in Mode 2 was not reported to the NRC within 60 days of when it should reasonably have been discovered. Specifically, in Modes 1, 2, and 3, TS surveillance requirement 3.6.1.3.1 allows the 20-inch and 24-inch primary containment vent and purge valves to be open for inerting, deinerting, pressure control, or other reasons provided that valve 27MOV-120 in the full flow line to the SGT system is closed. This is to ensure that there would be no damage to the SGT filters if a loss-of-coolant accident were to occur with the vent and purge valves open. However, on November 24, 2012, operators transitioned the reactor from Mode 4 to Mode 2 while the 20-inch and 24-inch containment vent and purge valves and valve 27MOV-120 were open. This condition was not reported to the NRC within 60 days of when it should reasonably have been discovered. As immediate corrective action, FitzPatrick staff entered the issue into the corrective action program as condition report (CR)-JAF-2013-01097.

The inspectors determined that the failure to submit an LER within 60 days in accordance with 10 CFR 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process in that a violation of site TSs was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement

Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.73 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013002](#) (*pdf*)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Obtain NRC Staff Review and Approval Prior to Changing the Technical Specification Definition of a Core Quadrant

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.59, "Changes, Tests, and Experiments," because Entergy personnel implemented a change to the technical specification (TS) definition of core quadrant without prior review and approval by the NRC staff in accordance with 10 CFR 50.59(c)(1)(i). Specifically, Entergy staff changed the definition of core quadrant in Revision 5 of reactor analyst procedure RAP-7.1.04C, "Neutron Instrumentation Monitoring During In-Core Fuel Handling," which allowed operators to interpret what constitute core quadrant boundaries such that core alterations could be performed anywhere in the core provided any three source range (neutron) monitors (SRMs) were operable. As immediate corrective action to the task interface agreement final response, FitzPatrick staff withdrew RAP-7.1.04C pending revision of the core quadrant definition. The inspectors verified that TS 3.3.1.2.2 had been satisfied during all core alterations that were performed during the 2010 and 2012 refueling outages using the standard definition of a core quadrant. Entergy staff entered this issue into the corrective action program as condition report (CR)-HQN-2013-00034.

The inspectors determined that Entergy staff's implementation of a redefinition of core quadrant prior to its review and approval by the NRC staff as specified in 10 CFR 50.59(c)(1)(i) was a performance deficiency that was reasonably within Entergy staff's ability to foresee and correct. Because this was a violation of 10 CFR 50.59, it was considered to be a violation that potentially impedes or impacts the regulatory process. Therefore, this violation was characterized using the traditional enforcement process. The violation was determined to be more than minor in accordance with the NRC Enforcement Manual, Section 7.3.E.6, because there was a reasonable likelihood that the change to the definition of what constituted a "core quadrant boundary" would require Commission review and approval prior to implementation. Additionally, the inspectors noted that in accordance with Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," the underlying performance deficiency would screen as more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, potentially inadequate SRM coverage during refueling operations could affect the TS bases function to provide early indication of unexpected subcritical multiplication that could be indicative of an approach to criticality. NRC Enforcement Manual Section 7.3 provides guidance to assess 10 CFR 50.59 violations through the significance determination process (SDP). In this case, the inspectors determined the violation could be evaluated using the SDP in accordance with IMC 0609 Appendix G, "Shutdown Operations Significance Determination Process," Checklist 7, "BWR Refueling Operation with RCS Level Greater Than 23 Feet." The finding affected the reactivity guidelines attribute that assumes existing core alteration TS are being met. Since this attribute does not require quantitative assessment, the finding was screened as Green in accordance with Section 3.3, "Mitigation Capability." In accordance with the NRC Enforcement Policy, Section 6.1.d.2, this violation was categorized as Severity Level IV because the issue was evaluated by the SDP as having very low safety significance (Green). The finding did not have a cross-cutting aspect because the performance deficiency did not occur within the past 3 years and, therefore, was not reflective of present performance.

Inspection Report# : [2013002](#) (*pdf*)

Significance: G Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure of 'A' EDG Output Breaker to Close Following Loss of Offsite Power

The inspectors identified a self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," because Entergy did not establish and implement an adequate procedure for installation of a 4160 volt alternating current (VAC) circuit breaker. Specifically, FitzPatrick's procedure for 4160 VAC circuit breaker installation did not provide sufficient guidance to station personnel to preclude physical misalignment of the 'A' emergency diesel generator (EDG) output breaker which occurred during installation on September 15, 2011, and resulted in failure of the breaker to close when required following a loss of offsite power on October 5, 2012. As immediate corrective action, the 'A' EDG output breaker was racked out, re-aligned in the cubicle, and racked back in such that it was no longer misaligned and was flush with the front of the cubicle. An instrumented test of the 'A' and 'C' EDGs was performed and all breakers operated correctly. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-06868. The finding was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the reliability of Division 1 EDG automatic operation was degraded for approximately one year due to the 'A' EDG breaker misalignment issue. Although the issue was identified while the plant was shut down, the inspectors determined that it was appropriate to evaluate the condition in accordance with the at-power SDP because the condition existed for the previous year. In accordance with Inspection Manual Chapter (IMC) 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that the finding was of very low safety significance because the finding was not a design qualification deficiency resulting in a loss of functionality or operability, did not represent an actual loss of safety function of a system or train of equipment, and was not potentially risk significant due to external initiating events. Specifically, the 'A' EDG breaker continued to perform its safety function as evidenced by monthly surveillance tests until the misalignment condition ultimately impacted its ability to close subsequent to October 3, 2012 testing. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick personnel did not ensure that a complete, accurate and up-to-date procedure was available for 4160 VAC circuit breaker installation. Specifically, procedure did not include steps to ensure correct alignment during breaker racking and to verify flush alignment [H.2(c)].

Inspection Report# : [2012005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : December 03, 2013

FitzPatrick

4Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Reactor Water Recirculation Digital Flow Control Modification Post-Maintenance Test Procedure Results in Unexpected Power Increase

The inspectors identified a Green self-revealing non-cited violation of Technical Specification (TS) 5.4, "Procedures," because Entergy Nuclear Northeast (Entergy) staff did not adequately preplan the implementation of a plant modification to install a digital reactor water recirculation (RWR) flow control system during the 2012 refueling outage. Specifically, post-maintenance testing (PMT) failed to identify that a portion of the runback logic was incorrectly programmed. As a result, the RWR system was restored to operation without identifying the error. On November 8, 2012, during power ascension activities following a subsequent forced outage, the 'A' RWR pump demand signal increased from minimum flow (approximately 30 percent) to approximately 44 percent with no operator action when feedwater flow increased above 20 percent. This resulted in an unexpected power increase of approximately 1.4 percent (37 megawatts thermal. As immediate corrective action, control room operators reduced flow in the 'A' RWR loop to restore it to pre-transient conditions, locked the scoop tubes for both RWR motor-generators, and placed the power ascension on hold pending further evaluation of the event. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-08042. The issue of inadequate PMT was subsequently entered into the CAP as CR-JAF-2013-05326.

The finding was more than minor because it was similar to Example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that it resulted in a plant transient. In addition, the finding adversely affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined this finding was of very low significance (Green) because the performance deficiency did not cause a reactor trip or the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy did not ensure that the PMT acceptance criteria specified in the engineering change package were clearly translated into PMT testing work packages to verify successful implementation of the digital RWR flow control modification [H.2(c)].

Inspection Report# : [2013004](#) (*pdf*)

Mitigating Systems

Significance: G Jul 11, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to correctly position EDG room ventilation temperature controllers in automatic

The team identified a finding of very low safety significance (Green) involving a non cited violation of Technical Specification (TS) 5.4, "Procedures." Specifically, following EDG maintenance, operators did not restore the 'A' and 'C' EDG ventilation systems in accordance with operating procedure OP-60, "Diesel Generator Room Ventilation." In particular, operators failed to correctly position the 'A' and 'C' EDG room ventilation temperature controllers to automatic as required by Entergy procedure OP-60. Following discovery, operators promptly restored controllers to automatic, performed additional extent-of-condition control panel walkdowns throughout the plant, and entered the issue into their corrective action program to evaluate and address causal factors.

The performance deficiency was determined to be more than minor because it was associated with the Configuration Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings at Power," Exhibit 2 – Mitigating Systems Screening Questions. The team determined that the finding was of very low safety significance because it was not a design qualification deficiency resulting in a loss of functionality or operability and did not represent an actual loss of safety function of a system or train of equipment. The team determined that this finding has a cross-cutting aspect in the area of Human Performance, Work Practices Component, because Entergy did not adequately ensure supervisory and management oversight of EDG ventilation system restoration activities such that nuclear safety was supported [H.4(c)].

Inspection Report# : [2013007](#) (pdf)

Significance:  Jul 11, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to verify adequacy of the FOTP NPSH

The team identified a finding of very low safety significance (Green) involving a non cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because Entergy had not verified the adequacy of the existing design analyses for the available net positive suction head (NPSH) to the EDG fuel oil transfer pumps. Specifically, the team identified several non-conservative design assumptions indicating that Entergy did not adequately account for NPSH in their calculation for the 7-day onsite supply of fuel oil to the EDGs. Entergy performed an operability evaluation, implemented appropriate compensatory measures, and entered the issue into their corrective action program to evaluate and resolve the design deficiency.

The performance deficiency was determined to be more than minor because it was similar to Example 3.j of NRC IMC 0612, Appendix E, and was associated with the Design Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings at Power," Exhibit 2 – Mitigating Systems screening questions. The finding was determined to be of very low safety significance because it was a design deficiency confirmed not to result in a loss of operability. This finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance. Specifically, the performance deficiency had occurred outside of the nominal three year period for evaluating present performance as defined in IMC 0612.

Inspection Report# : [2013007](#) (pdf)

Significance:  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Technical Specification Actions for Inoperable Control Rod Not Performed Within the Technical Specification Allowed Completion

The inspectors identified a non-cited violation of technical specification (TS) 3.1.3, “Control Rod Operability,” because Entergy operators did not take the required actions within the allowed completion time in response to indication that the scram capability of a control rod was indeterminate. Specifically, when available information concerning the scram solenoid pilot valves (SSPVs) required control rod 30-11 to be declared inoperable, operators did not declare the control rod inoperable, did not fully insert the control rod within 3 hours, and did not disarm the associated control rod drive within 4 hours as required by TS 3.1.3.C. Entergy’s corrective actions included fully inserting and electrically disarming control rod 30-11, replacing the SSPVs, revising the instructions to operators, briefing operators on this issue, and initiating a condition report.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, operators did not fully insert and electrically disarm control rod 30-11 within the TS allowed completion time when the scram capability of the control rod was indeterminate and, therefore, required to be declared inoperable. In accordance with Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process for Findings At Power,” the finding was of very low safety significance (Green) because it did not affect multiple automatic reactor shutdown functions, did not involve an unintentional positive reactivity addition, and did not result in inability to control changes in reactivity during crew operations. The finding had a cross-cutting aspect in the area of Human Performance, Decision Making, because, given industry operating experience that cessation of the SSPV buzzing sound was a possible indication of a condition that would prevent the SSPV from performing its safety function. Entergy staff did not communicate to on-shift operations department personnel the need to promptly declare control rod 30-11 inoperable if this condition were to occur [H.1(c)].

Inspection Report# : [2013003](#) (*pdf*)

Significance:  Jun 30, 2013

Identified By: NRC

Item Type: FIN Finding

Inadequate Corrective Action for Decay Heat Removal System Degradation Results in Loss of Decay Heat Removal During Refueling Outage 20

A self-revealing finding (FIN) was identified for a loss of decay heat removal (DHR) during refueling outage 20 (R20) that was the result of inadequately remediated DHR system degradation. Specifically, prior to using the system during R20, Entergy did not clean scale buildup in the DHR secondary cooling loop heat exchangers (HXs) causing low secondary system pressure, and Entergy did not address the resultant reduction in margin to the primary cooling loop pump automatic shutdown on low primary-to-secondary differential pressure. As a result, a spurious automatic DHR system shutdown occurred while it was functioning as the alternate method of DHR in place of residual heat removal (RHR) shutdown cooling. Entergy’s corrective actions included restarting DHR and initiating condition report CR-JAF-2012-06934. Entergy also initiated actions to evaluate corrective measures such as modifying the differential pressure trip, adding secondary loop water chemistry treatment, and cleaning of the HXs.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, there was an unplanned shutdown of the DHR system for about 50 minutes when it was providing the shutdown cooling function. The inspectors determined the significance of the finding using Inspection Manual Chapter 0609, Appendix G, “Shutdown Operations Significance Determination Process.” Per Attachment 1, “Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for both PWRs [pressurized water reactors] and BWRs [boiling water reactors],” Checklist 7, “BWR Refueling Operation with RCS Level > 23’,” this finding impacted checklist item I.C because at the time of the event, the DHR system was functioning as the alternate method of DHR in place of RHR shutdown cooling. The finding was determined to be of

very low safety significance (Green) because the finding did not require a quantitative assessment as described in Checklist 7 of Attachment 1 to Appendix G, because checklist item I.C. is not listed as requiring phase 2 or 3 analysis, and the finding did not constitute a loss of control event per Appendix G, Table 1. The inspectors determined that the finding had a cross-cutting aspect in the Problem Identification and Resolution area, Corrective Action Program component, because Entergy staff did not take appropriate corrective actions to address the adverse trend in DHR system performance [P.1(d)].

Inspection Report# : [2013003](#) (*pdf*)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Licensee Event Report for a Condition That Could Have Prevented Fulfillment of the High-Pressure Coolant Injection System Safety Function

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.73, "Licensee Event Report (LER) System," because failure of an isolation valve in the high-pressure coolant injection (HPCI) system torus suction line to fully open on demand caused the automatic suction swap function to be inoperable, but this condition was not reported to the NRC as a condition that could have prevented fulfillment of a safety function per 10 CFR 50.73(a)(v) within 60 days of when it should reasonably have been discovered. Specifically, while this condition existed, an automatic suction swap from the condensate storage tanks (CSTs) to the torus would not have gone to completion, but rather would have stopped with both suction paths open. Depending on whether or not HPCI was running at the time, this would either result in air entrainment in the HPCI pump suction, causing a loss of HPCI, or an increase in suppression pool level due to drainage from the CSTs. However, this condition was not reported to the NRC as a condition that could have prevented fulfillment of a safety function per 10 CFR 50.73(a)(v) within 60 days of when it should reasonably have been discovered. This issue was entered into the corrective action program as condition report (CR)-JAF-2013-01768.

The inspectors determined that the failure to submit an LER within 60 days in accordance with 10 CFR 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.73 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013002](#) (*pdf*)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Licensee Event Report for Condition Prohibited by Technical Specification 3.0.4

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.73, "Licensee Event Report (LER) System," because a violation of technical specification (TS) 3.0.4 for a reactor mode change being made from Mode 4 to Mode 2 without satisfying the TS required conditions for alignment of the containment air dilution and standby gas treatment (SGT) systems in Mode 2 was not reported to the NRC within 60 days of when it should reasonably have been discovered. Specifically, in Modes 1, 2, and 3, TS surveillance requirement 3.6.1.3.1 allows the 20-inch and 24-inch primary containment vent and purge valves to be open for inerting, deinerting, pressure control, or other reasons provided that valve 27MOV-120 in the full flow line to the SGT system is closed. This is to ensure that there would be no damage to the SGT filters if a loss-of-coolant accident were

to occur with the vent and purge valves open. However, on November 24, 2012, operators transitioned the reactor from Mode 4 to Mode 2 while the 20-inch and 24-inch containment vent and purge valves and valve 27MOV-120 were open. This condition was not reported to the NRC within 60 days of when it should reasonably have been discovered. As immediate corrective action, FitzPatrick staff entered the issue into the corrective action program as condition report (CR)-JAF-2013-01097.

The inspectors determined that the failure to submit an LER within 60 days in accordance with 10 CFR 50.73 was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process in that a violation of site TSs was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.73 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013002](#) (*pdf*)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Obtain NRC Staff Review and Approval Prior to Changing the Technical Specification Definition of a Core Quadrant

The inspectors identified a Severity Level IV non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.59, "Changes, Tests, and Experiments," because Entergy personnel implemented a change to the technical specification (TS) definition of core quadrant without prior review and approval by the NRC staff in accordance with 10 CFR 50.59(c)(1)(i). Specifically, Entergy staff changed the definition of core quadrant in Revision 5 of reactor analyst procedure RAP-7.1.04C, "Neutron Instrumentation Monitoring During In-Core Fuel Handling," which allowed operators to interpret what constitute core quadrant boundaries such that core alterations could be performed anywhere in the core provided any three source range (neutron) monitors (SRMs) were operable. As immediate corrective action to the task interface agreement final response, FitzPatrick staff withdrew RAP-7.1.04C pending revision of the core quadrant definition. The inspectors verified that TS 3.3.1.2.2 had been satisfied during all core alterations that were performed during the 2010 and 2012 refueling outages using the standard definition of a core quadrant. Entergy staff entered this issue into the corrective action program as condition report (CR)-HQN-2013-00034.

The inspectors determined that Entergy staff's implementation of a redefinition of core quadrant prior to its review and approval by the NRC staff as specified in 10 CFR 50.59(c)(1)(i) was a performance deficiency that was reasonably within Entergy staff's ability to foresee and correct. Because this was a violation of 10 CFR 50.59, it was considered to be a violation that potentially impedes or impacts the regulatory process. Therefore, this violation was characterized using the traditional enforcement process. The violation was determined to be more than minor in accordance with the NRC Enforcement Manual, Section 7.3.E.6, because there was a reasonable likelihood that the change to the definition of what constituted a "core quadrant boundary" would require Commission review and approval prior to implementation. Additionally, the inspectors noted that in accordance with Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," the underlying performance deficiency would screen as more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, potentially inadequate SRM coverage during refueling operations could affect the TS bases function to provide early indication of unexpected subcritical multiplication that could be indicative of an approach to criticality. NRC Enforcement Manual Section 7.3 provides guidance to assess 10 CFR 50.59 violations through the significance determination process (SDP). In this case, the inspectors determined the violation could be evaluated using the SDP in

accordance with IMC 0609 Appendix G, “Shutdown Operations Significance Determination Process,” Checklist 7, “BWR Refueling Operation with RCS Level Greater Than 23 Feet.” The finding affected the reactivity guidelines attribute that assumes existing core alteration TS are being met. Since this attribute does not require quantitative assessment, the finding was screened as Green in accordance with Section 3.3, “Mitigation Capability.” In accordance with the NRC Enforcement Policy, Section 6.1.d.2, this violation was categorized as Severity Level IV because the issue was evaluated by the SDP as having very low safety significance (Green). The finding did not have a cross-cutting aspect because the performance deficiency did not occur within the past 3 years and, therefore, was not reflective of present performance.

Inspection Report# : [2013002](#) (pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual

respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : February 24, 2014

FitzPatrick

1Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

HPCI System Inoperable for Longer than Allowed by TS

The inspectors identified a Green NCV of Technical Specification (TS) 3.5.1, "ECCS [emergency core cooling system] - Operating," because filling the high pressure coolant injection (HPCI) system with low quality water from the suppression pool following maintenance caused the HPCI booster pump recirculation pressure control valve, 23PCV-50, to fail, thereby making the HPCI system inoperable, and this condition existed for greater than the TS allowed outage time of 14 days. Although the HPCI system was inoperable, it still maintained its safety function to provide emergency core coolant flow in the event of an accident. As corrective action, Entergy staff changed the procedure to indicate that the HPCI system should be filled using the CSTs, and submitted revision 1 to the associated licensee event report (LER) to report the TS violation. This issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2014-00961.

The inspectors determined that Entergy staff's actions to refill the HPCI system with water from the suppression pool following maintenance, thereby causing the failure of 23PCV-50 to control pressure the next time that the HPCI system was operated, was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the issue resulted in failure of 23PCV-50 to control pressure, which caused the HPCI system to be inoperable for greater than its TS allowed outage time. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, because FitzPatrick staff did not implement internal and external operating experience concerning the inadvisability of using suppression pool water to refill the HPCI system following maintenance.

Inspection Report# : [2014002](#) (*pdf*)

Significance: N/A Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely 10 CFR 50.72 Notification of a HPCI System Functional Failure

The inspectors identified a Severity Level IV (SL IV) NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the high pressure coolant injection (HPCI) system was not reported to the NRC within eight hours of when it should reasonably have been discovered, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, identification that issues with two of the

condensate storage tank (CST) level detectors that provide automatic transfer of the HPCI suction from the CSTs to the suppression pool would have caused this transfer to occur at less than the minimum CST level allowed by Technical Specifications (TSs) and therefore caused the HPCI system to be inoperable, was not promptly recognized as a condition reportable under 10 CFR 50.72. This issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2013-06344.

The inspectors determined that the failure to inform the NRC of the HPCI system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process; in that, a safety system functional failure was not reported to the NRC within the required timeframe thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013005](#) (*pdf*)

Significance:  Sep 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Reactor Water Recirculation Digital Flow Control Modification Post-Maintenance Test Procedure Results in Unexpected Power Increase

The inspectors identified a Green self-revealing non-cited violation of Technical Specification (TS) 5.4, "Procedures," because Entergy Nuclear Northeast (Entergy) staff did not adequately preplan the implementation of a plant modification to install a digital reactor water recirculation (RWR) flow control system during the 2012 refueling outage. Specifically, post-maintenance testing (PMT) failed to identify that a portion of the runback logic was incorrectly programmed. As a result, the RWR system was restored to operation without identifying the error. On November 8, 2012, during power ascension activities following a subsequent forced outage, the 'A' RWR pump demand signal increased from minimum flow (approximately 30 percent) to approximately 44 percent with no operator action when feedwater flow increased above 20 percent. This resulted in an unexpected power increase of approximately 1.4 percent (37 megawatts thermal). As immediate corrective action, control room operators reduced flow in the 'A' RWR loop to restore it to pre-transient conditions, locked the scoop tubes for both RWR motor-generators, and placed the power ascension on hold pending further evaluation of the event. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-08042. The issue of inadequate PMT was subsequently entered into the CAP as CR-JAF-2013-05326.

The finding was more than minor because it was similar to Example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that it resulted in a plant transient. In addition, the finding adversely affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined this finding was of very low significance (Green) because the performance deficiency did not cause a reactor trip or the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy did not ensure that the PMT acceptance criteria specified in the engineering change package were clearly translated into PMT testing work packages to verify successful implementation of the digital RWR flow control modification [H.2(c)].

Inspection Report# : [2013004](#) (*pdf*)

Mitigating Systems

Significance:  Jul 11, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correctly Position EDG Room Ventilation Temperature Controllers in Automatic

The team identified a finding of very low safety significance (Green) involving a non cited violation of Technical Specification (TS) 5.4, "Procedures." Specifically, following EDG maintenance, operators did not restore the 'A' and 'C' EDG ventilation systems in accordance with operating procedure OP-60, "Diesel Generator Room Ventilation." In particular, operators failed to correctly position the 'A' and 'C' EDG room ventilation temperature controllers to automatic as required by Entergy procedure OP-60. Following discovery, operators promptly restored controllers to automatic, performed additional extent-of-condition control panel walkdowns throughout the plant, and entered the issue into their corrective action program to evaluate and address causal factors.

The performance deficiency was determined to be more than minor because it was associated with the Configuration Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings at Power," Exhibit 2 – Mitigating Systems Screening Questions. The team determined that the finding was of very low safety significance because it was not a design qualification deficiency resulting in a loss of functionality or operability and did not represent an actual loss of safety function of a system or train of equipment. The team determined that this finding has a cross-cutting aspect in the area of Human Performance, Work Practices Component, because Entergy did not adequately ensure supervisory and management oversight of EDG ventilation system restoration activities such that nuclear safety was supported [H.4(c)].

Inspection Report# : [2013007](#) (*pdf*)

Significance:  Jul 11, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Verify Adequacy of the FOTP NPSH

The team identified a finding of very low safety significance (Green) involving a non cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because Entergy had not verified the adequacy of the existing design analyses for the available net positive suction head (NPSH) to the EDG fuel oil transfer pumps. Specifically, the team identified several non-conservative design assumptions indicating that Entergy did not adequately account for NPSH in their calculation for the 7-day onsite supply of fuel oil to the EDGs. Entergy performed an operability evaluation, implemented appropriate compensatory measures, and entered the issue into their corrective action program to evaluate and resolve the design deficiency.

The performance deficiency was determined to be more than minor because it was similar to Example 3.j of NRC IMC 0612, Appendix E, and was associated with the Design Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings at Power," Exhibit 2 – Mitigating Systems screening questions. The finding was determined to be of very low safety significance because it was a design deficiency confirmed not to result in a loss of operability. This finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance. Specifically, the performance deficiency had occurred outside of the nominal three year period for evaluating present performance as defined in

IMC 0612.

Inspection Report# : [2013007](#) (pdf)**Significance:** G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Technical Specification Actions for Inoperable Control Rod Not Performed Within the Technical Specification Allowed Completion

The inspectors identified a non-cited violation of technical specification (TS) 3.1.3, "Control Rod Operability," because Entergy operators did not take the required actions within the allowed completion time in response to indication that the scram capability of a control rod was indeterminate. Specifically, when available information concerning the scram solenoid pilot valves (SSPVs) required control rod 30-11 to be declared inoperable, operators did not declare the control rod inoperable, did not fully insert the control rod within 3 hours, and did not disarm the associated control rod drive within 4 hours as required by TS 3.1.3.C. Entergy's corrective actions included fully inserting and electrically disarming control rod 30-11, replacing the SSPVs, revising the instructions to operators, briefing operators on this issue, and initiating a condition report.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, operators did not fully insert and electrically disarm control rod 30-11 within the TS allowed completion time when the scram capability of the control rod was indeterminate and, therefore, required to be declared inoperable. In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At Power," the finding was of very low safety significance (Green) because it did not affect multiple automatic reactor shutdown functions, did not involve an unintentional positive reactivity addition, and did not result in inability to control changes in reactivity during crew operations. The finding had a cross-cutting aspect in the area of Human Performance, Decision Making, because, given industry operating experience that cessation of the SSPV buzzing sound was a possible indication of a condition that would prevent the SSPV from performing its safety function. Entergy staff did not communicate to on-shift operations department personnel the need to promptly declare control rod 30-11 inoperable if this condition were to occur [H.1(c)].

Inspection Report# : [2013003](#) (pdf)**Significance:** G Jun 30, 2013

Identified By: NRC

Item Type: FIN Finding

Inadequate Corrective Action for Decay Heat Removal System Degradation Results in Loss of Decay Heat Removal During Refueling Outage 20

A self-revealing finding (FIN) was identified for a loss of decay heat removal (DHR) during refueling outage 20 (R20) that was the result of inadequately remediated DHR system degradation. Specifically, prior to using the system during R20, Entergy did not clean scale buildup in the DHR secondary cooling loop heat exchangers (HXs) causing low secondary system pressure, and Entergy did not address the resultant reduction in margin to the primary cooling loop pump automatic shutdown on low primary-to-secondary differential pressure. As a result, a spurious automatic DHR system shutdown occurred while it was functioning as the alternate method of DHR in place of residual heat removal (RHR) shutdown cooling. Entergy's corrective actions included restarting DHR and initiating condition report CR-JAF-2012-06934. Entergy also initiated actions to evaluate corrective measures such as modifying the differential pressure trip, adding secondary loop water chemistry treatment, and cleaning of the HXs.

This finding was more than minor because it was associated with the equipment performance attribute of the

Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, there was an unplanned shutdown of the DHR system for about 50 minutes when it was providing the shutdown cooling function. The inspectors determined the significance of the finding using Inspection Manual Chapter 0609, Appendix G, “Shutdown Operations Significance Determination Process.” Per Attachment 1, “Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for both PWRs [pressurized water reactors] and BWRs [boiling water reactors],” Checklist 7, “BWR Refueling Operation with RCS Level > 23’,” this finding impacted checklist item I.C because at the time of the event, the DHR system was functioning as the alternate method of DHR in place of RHR shutdown cooling. The finding was determined to be of very low safety significance (Green) because the finding did not require a quantitative assessment as described in Checklist 7 of Attachment 1 to Appendix G, because checklist item I.C. is not listed as requiring phase 2 or 3 analysis, and the finding did not constitute a loss of control event per Appendix G, Table 1. The inspectors determined that the finding had a cross-cutting aspect in the Problem Identification and Resolution area, Corrective Action Program component, because Entergy staff did not take appropriate corrective actions to address the adverse trend in DHR system performance [P.1(d)].

Inspection Report# : [2013003](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : May 30, 2014

FitzPatrick

2Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

HPCI System Inoperable for Longer than Allowed by TS

The inspectors identified a Green NCV of Technical Specification (TS) 3.5.1, "ECCS [emergency core cooling system] - Operating," because filling the high pressure coolant injection (HPCI) system with low quality water from the suppression pool following maintenance caused the HPCI booster pump recirculation pressure control valve, 23PCV-50, to fail, thereby making the HPCI system inoperable, and this condition existed for greater than the TS allowed outage time of 14 days. Although the HPCI system was inoperable, it still maintained its safety function to provide emergency core coolant flow in the event of an accident. As corrective action, Entergy staff changed the procedure to indicate that the HPCI system should be filled using the CSTs, and submitted revision 1 to the associated licensee event report (LER) to report the TS violation. This issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2014-00961.

The inspectors determined that Entergy staff's actions to refill the HPCI system with water from the suppression pool following maintenance, thereby causing the failure of 23PCV-50 to control pressure the next time that the HPCI system was operated, was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the issue resulted in failure of 23PCV-50 to control pressure, which caused the HPCI system to be inoperable for greater than its TS allowed outage time. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, because FitzPatrick staff did not implement internal and external operating experience concerning the inadvisability of using suppression pool water to refill the HPCI system following maintenance.

Inspection Report# : [2014002](#) (*pdf*)

Significance: N/A Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely 10 CFR 50.72 Notification of a HPCI System Functional Failure

The inspectors identified a Severity Level IV (SL IV) NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the high pressure coolant injection (HPCI) system was not reported to the NRC within eight hours of when it should reasonably have been discovered, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, identification that issues with two of the

condensate storage tank (CST) level detectors that provide automatic transfer of the HPCI suction from the CSTs to the suppression pool would have caused this transfer to occur at less than the minimum CST level allowed by Technical Specifications (TSs) and therefore caused the HPCI system to be inoperable, was not promptly recognized as a condition reportable under 10 CFR 50.72. This issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2013-06344.

The inspectors determined that the failure to inform the NRC of the HPCI system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process; in that, a safety system functional failure was not reported to the NRC within the required timeframe thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013005](#) (*pdf*)

Significance: G Sep 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Reactor Water Recirculation Digital Flow Control Modification Post-Maintenance Test Procedure Results in Unexpected Power Increase

The inspectors identified a Green self-revealing non-cited violation of Technical Specification (TS) 5.4, "Procedures," because Entergy Nuclear Northeast (Entergy) staff did not adequately preplan the implementation of a plant modification to install a digital reactor water recirculation (RWR) flow control system during the 2012 refueling outage. Specifically, post-maintenance testing (PMT) failed to identify that a portion of the runback logic was incorrectly programmed. As a result, the RWR system was restored to operation without identifying the error. On November 8, 2012, during power ascension activities following a subsequent forced outage, the 'A' RWR pump demand signal increased from minimum flow (approximately 30 percent) to approximately 44 percent with no operator action when feedwater flow increased above 20 percent. This resulted in an unexpected power increase of approximately 1.4 percent (37 megawatts thermal. As immediate corrective action, control room operators reduced flow in the 'A' RWR loop to restore it to pre-transient conditions, locked the scoop tubes for both RWR motor-generators, and placed the power ascension on hold pending further evaluation of the event. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2012-08042. The issue of inadequate PMT was subsequently entered into the CAP as CR-JAF-2013-05326.

The finding was more than minor because it was similar to Example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," in that it resulted in a plant transient. In addition, the finding adversely affected the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined this finding was of very low significance (Green) because the performance deficiency did not cause a reactor trip or the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because Entergy did not ensure that the PMT acceptance criteria specified in the engineering change package were clearly translated into PMT testing work packages to verify successful implementation of the digital RWR flow control modification [H.2(c)].

Inspection Report# : [2013004](#) (*pdf*)

Mitigating Systems

Significance:  Jul 11, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correctly Position EDG Room Ventilation Temperature Controllers in Automatic

The team identified a finding of very low safety significance (Green) involving a non cited violation of Technical Specification (TS) 5.4, "Procedures." Specifically, following EDG maintenance, operators did not restore the 'A' and 'C' EDG ventilation systems in accordance with operating procedure OP-60, "Diesel Generator Room Ventilation." In particular, operators failed to correctly position the 'A' and 'C' EDG room ventilation temperature controllers to automatic as required by Entergy procedure OP-60. Following discovery, operators promptly restored controllers to automatic, performed additional extent-of-condition control panel walkdowns throughout the plant, and entered the issue into their corrective action program to evaluate and address causal factors.

The performance deficiency was determined to be more than minor because it was associated with the Configuration Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings at Power," Exhibit 2 – Mitigating Systems Screening Questions. The team determined that the finding was of very low safety significance because it was not a design qualification deficiency resulting in a loss of functionality or operability and did not represent an actual loss of safety function of a system or train of equipment. The team determined that this finding has a cross-cutting aspect in the area of Human Performance, Work Practices Component, because Entergy did not adequately ensure supervisory and management oversight of EDG ventilation system restoration activities such that nuclear safety was supported [H.4(c)].

Inspection Report# : [2013007](#) (*pdf*)

Significance:  Jul 11, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Verify Adequacy of the FOTP NPSH

The team identified a finding of very low safety significance (Green) involving a non cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because Entergy had not verified the adequacy of the existing design analyses for the available net positive suction head (NPSH) to the EDG fuel oil transfer pumps. Specifically, the team identified several non-conservative design assumptions indicating that Entergy did not adequately account for NPSH in their calculation for the 7-day onsite supply of fuel oil to the EDGs. Entergy performed an operability evaluation, implemented appropriate compensatory measures, and entered the issue into their corrective action program to evaluate and resolve the design deficiency.

The performance deficiency was determined to be more than minor because it was similar to Example 3.j of NRC IMC 0612, Appendix E, and was associated with the Design Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings at Power," Exhibit 2 – Mitigating Systems screening questions. The finding was determined to be of very low safety significance because it was a design deficiency confirmed not to result in a loss of operability. This finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance. Specifically, the performance deficiency had occurred outside of the nominal three year period for evaluating present performance as defined in

IMC 0612.

Inspection Report# : [2013007](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Ship RAM-QC

Green. The inspectors identified a Green NCV of 10 CFR 71.5, "Transportation of Licensed Material," and 49 CFR 172, Subpart I, "Safety and Security Plans." Specifically, Entergy personnel shipped a radioactive quantity of category 2 Radioactive Material in Quantities of Concern (RAM-QC) on the public highways to a waste processor without adhering to its transportation security plan. Prior to shipment, Entergy staff failed to recognize that the quantity of radioactive material met the definition of RAM-QC. Entergy staff entered this issue into their corrective action program (CAP) as condition report (CR) JAF 2014 02337.

The issue was more than minor because it was associated with the Program and Process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain. In accordance with IMC 0609, Appendix D, "Public Radiation Safety Significance Determination Process," the finding was determined to be of very low safety significance (Green) because Entergy had an issue involving transportation of radioactive material, but it did not involve: (1) a radiation limit exceeded; (2) a breach of package during transport; (3) a certificate of compliance issue; (4) a low level burial ground nonconformance; or (5) a failure to make notifications or provide emergency information. This finding had a cross-cutting aspect in the area of Human Performance, Work Processes, in that the documentation (procedures) to support this activity was inadequate [H.7]. (Section 2RS8)

Inspection Report# : [2014003](#) (*pdf*)

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission

has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A May 03, 2014

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. Entergy personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. Entergy staff appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Entergy typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Entergy staff adequately identified, reviewed, and applied relevant industry operating experience to FitzPatrick operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were thorough.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2014009](#) (*pdf*)

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : August 29, 2014

FitzPatrick

3Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

HPCI System Inoperable for Longer than Allowed by TS

The inspectors identified a Green NCV of Technical Specification (TS) 3.5.1, "ECCS [emergency core cooling system] - Operating," because filling the high pressure coolant injection (HPCI) system with low quality water from the suppression pool following maintenance caused the HPCI booster pump recirculation pressure control valve, 23PCV-50, to fail, thereby making the HPCI system inoperable, and this condition existed for greater than the TS allowed outage time of 14 days. Although the HPCI system was inoperable, it still maintained its safety function to provide emergency core coolant flow in the event of an accident. As corrective action, Entergy staff changed the procedure to indicate that the HPCI system should be filled using the CSTs, and submitted revision 1 to the associated licensee event report (LER) to report the TS violation. This issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2014-00961.

The inspectors determined that Entergy staff's actions to refill the HPCI system with water from the suppression pool following maintenance, thereby causing the failure of 23PCV-50 to control pressure the next time that the HPCI system was operated, was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the issue resulted in failure of 23PCV-50 to control pressure, which caused the HPCI system to be inoperable for greater than its TS allowed outage time. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, because FitzPatrick staff did not implement internal and external operating experience concerning the inadvisability of using suppression pool water to refill the HPCI system following maintenance.

Inspection Report# : [2014002](#) (*pdf*)

Significance: N/A Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely 10 CFR 50.72 Notification of a HPCI System Functional Failure

The inspectors identified a Severity Level IV (SL IV) NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the high pressure coolant injection (HPCI) system was not reported to the NRC within eight hours of when it should reasonably have been discovered, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, identification that issues with two of the

condensate storage tank (CST) level detectors that provide automatic transfer of the HPCI suction from the CSTs to the suppression pool would have caused this transfer to occur at less than the minimum CST level allowed by Technical Specifications (TSs) and therefore caused the HPCI system to be inoperable, was not promptly recognized as a condition reportable under 10 CFR 50.72. This issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2013-06344.

The inspectors determined that the failure to inform the NRC of the HPCI system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. Because the issue impacted the regulatory process; in that, a safety system functional failure was not reported to the NRC within the required timeframe thereby delaying the NRC's opportunity to review the matter, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2013005](#) (*pdf*)

Mitigating Systems

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Ship RAM-QC

Green. The inspectors identified a Green NCV of 10 CFR 71.5, "Transportation of Licensed Material," and 49 CFR 172, Subpart I, "Safety and Security Plans." Specifically, Entergy personnel shipped a radioactive quantity of category 2 Radioactive Material in Quantities of Concern (RAM-QC) on the public highways to a waste processor without adhering to its transportation security plan. Prior to shipment, Entergy staff failed to recognize that the quantity of radioactive material met the definition of RAM-QC. Entergy staff entered this issue into their corrective action

program (CAP) as condition report (CR) JAF 2014 02337.

The issue was more than minor because it was associated with the Program and Process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain. In accordance with IMC 0609, Appendix D, "Public Radiation Safety Significance Determination Process," the finding was determined to be of very low safety significance (Green) because Entergy had an issue involving transportation of radioactive material, but it did not involve: (1) a radiation limit exceeded; (2) a breach of package during transport; (3) a certificate of compliance issue; (4) a low level burial ground nonconformance; or (5) a failure to make notifications or provide emergency information. This finding had a cross-cutting aspect in the area of Human Performance, Work Processes, in that the documentation (procedures) to support this activity was inadequate [H.7]. (Section 2RS8)

Inspection Report# : [2014003](#) (*pdf*)

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A May 03, 2014

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. Entergy personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. Entergy staff appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Entergy typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Entergy staff adequately identified, reviewed, and applied relevant industry operating experience to FitzPatrick operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were thorough.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2014009](#) (*pdf*)

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : November 26, 2014

FitzPatrick 4Q/2014 Plant Inspection Findings

Initiating Events

Significance: N/A Sep 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Notify NRC Within 30 Days of Medical Changes for Licensed Operators

The inspectors identified a Severity Level (SL) IV NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, on three occasions, Entergy staff did not notify the NRC of a change in the medical status of a licensed operator within 30 days of learning of the diagnosis. These issues were entered into the corrective action program (CAP) as condition report (CR)-JAF-2014-02227 and CR-JAF-2014-02304.

The inspectors determined that Entergy's failure to notify the NRC of licensed operator medical status changes as described above within 30 days was a performance deficiency that was within Entergy's ability to foresee and correct and should have been prevented. Because the issue had the potential to affect the NRC's ability to perform its regulatory function, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.4.d.1(b) from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation because Entergy staff did not communicate licensed operator permanent medical status changes within the 30 day reporting requirement for three licensed operators. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects. Inspection Report# : [2014004](#) (*pdf*)

Significance:  Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

HPCI System Inoperable for Longer than Allowed by TS

The inspectors identified a Green NCV of Technical Specification (TS) 3.5.1, "ECCS [emergency core cooling system] - Operating," because filling the high pressure coolant injection (HPCI) system with low quality water from the suppression pool following maintenance caused the HPCI booster pump recirculation pressure control valve, 23PCV-50, to fail, thereby making the HPCI system inoperable, and this condition existed for greater than the TS allowed outage time of 14 days. Although the HPCI system was inoperable, it still maintained its safety function to provide emergency core coolant flow in the event of an accident. As corrective action, Entergy staff changed the procedure to indicate that the HPCI system should be filled using the CSTs, and submitted revision 1 to the associated licensee event report (LER) to report the TS violation. This issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2014-00961.

The inspectors determined that Entergy staff's actions to refill the HPCI system with water from the suppression pool following maintenance, thereby causing the failure of 23PCV-50 to control pressure the next time that the HPCI system was operated, was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the issue

resulted in failure of 23PCV-50 to control pressure, which caused the HPCI system to be inoperable for greater than its TS allowed outage time. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, because FitzPatrick staff did not implement internal and external operating experience concerning the inadvisability of using suppression pool water to refill the HPCI system following maintenance.

Inspection Report# : [2014002](#) (*pdf*)

Mitigating Systems

Significance: N/A Dec 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely 10 CFR 50.72 Notification of a Secondary Containment System Functional Failure

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the secondary containment system was not reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, while restoring the normal reactor building ventilation system to service following maintenance, reactor building-to-ambient differential pressure dropped below the Technical Specification (TS) required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. However, FitzPatrick staff did not promptly recognize this as a condition reportable under 10 CFR 50.72. As corrective action, FitzPatrick staff reported the condition to the NRC in accordance with 10 CFR 50.72 (b)(3)(v) and entered it into the corrective action program (CAP) as condition report (CR)-JAF-2014-06498.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2014005](#) (*pdf*)

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

TS Actions for Inoperable ECCS Not Performed Within the TS Allowed Completion Time

The inspectors identified a Green NCV for two violations of TS 3.5.1, “ECCS [emergency core cooling systems] - Operating,” associated with the non-functionality of east crescent area ventilation and cooling (CAVC) subsystem unit cooler 66UC-22H. Specifically, during the periods May 5 through May 21, 2010, and March 15 through March 25, 2011, the Technical Requirements Manual (TRM) requirements for east crescent unit cooler operability were not satisfied for longer than the allowed outage time (AOT), which caused the ECCS in the east crescent to become inoperable and remain so for longer than the TS AOT without completion of the required plant mode changes. As immediate corrective action, Entergy personnel reconditioned the fan motor contactor for the affected unit cooler to obtain satisfactory low voltage pickup response. The issue was entered into Entergy’s CAP as CR-JAF-2012-00584 and CR-JAF-2012-02288.

The finding was more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the unsatisfactory low voltage response of the 66UC-22H fan motor contactor, along with the unavailability of another east CAVC unit cooler due to maintenance, could have degraded the capability of ECCS systems in the east crescent area during an accident concurrent with degraded voltage conditions. In light of FitzPatrick staff’s determination that there was reasonable assurance that the remaining three operable unit coolers would have been capable of removing required post-accident heat loads, the inspectors determined that the finding was of very low safety significance (Green) in accordance with IMC 0609.04, “Initial Characterization of Findings,” and Exhibit 2 of IMC 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS AOT, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Resolution, because FitzPatrick staff did not take effective corrective actions to address the low voltage pickup issue in a timely manner commensurate with its safety significance [P.3].

Inspection Report# : [2014005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Ship RAM-QC

Green. The inspectors identified a Green NCV of 10 CFR 71.5, "Transportation of Licensed Material," and 49 CFR 172, Subpart I, "Safety and Security Plans." Specifically, Entergy personnel shipped a radioactive quantity of category 2 Radioactive Material in Quantities of Concern (RAM-QC) on the public highways to a waste processor without adhering to its transportation security plan. Prior to shipment, Entergy staff failed to recognize that the quantity of radioactive material met the definition of RAM-QC. Entergy staff entered this issue into their corrective action program (CAP) as condition report (CR) JAF 2014 02337.

The issue was more than minor because it was associated with the Program and Process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain. In accordance with IMC 0609, Appendix D, "Public Radiation Safety Significance Determination Process," the finding was determined to be of very low safety significance (Green) because Entergy had an issue involving transportation of radioactive material, but it did not involve: (1) a radiation limit exceeded; (2) a breach of package during transport; (3) a certificate of compliance issue; (4) a low level burial ground nonconformance; or (5) a failure to make notifications or provide emergency information. This finding had a cross-cutting aspect in the area of Human Performance, Work Processes, in that the documentation (procedures) to support this activity was inadequate [H.7]. (Section 2RS8)

Inspection Report# : [2014003](#) (*pdf*)

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A May 03, 2014

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. Entergy personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. Entergy staff appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Entergy typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Entergy staff adequately identified, reviewed, and applied relevant industry operating experience to FitzPatrick operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were thorough.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities,

and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2014009](#) (*pdf*)

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : February 26, 2015

FitzPatrick 1Q/2015 Plant Inspection Findings

Initiating Events

Significance: N/A Sep 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Notify NRC Within 30 Days of Medical Changes for Licensed Operators

The inspectors identified a Severity Level (SL) IV NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, on three occasions, Entergy staff did not notify the NRC of a change in the medical status of a licensed operator within 30 days of learning of the diagnosis. These issues were entered into the corrective action program (CAP) as condition report (CR)-JAF-2014-02227 and CR-JAF-2014-02304.

The inspectors determined that Entergy's failure to notify the NRC of licensed operator medical status changes as described above within 30 days was a performance deficiency that was within Entergy's ability to foresee and correct and should have been prevented. Because the issue had the potential to affect the NRC's ability to perform its regulatory function, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.4.d.1(b) from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation because Entergy staff did not communicate licensed operator permanent medical status changes within the 30 day reporting requirement for three licensed operators. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects. Inspection Report# : [2014004](#) (*pdf*)

Mitigating Systems

Significance: N/A Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of a Secondary Containment System Functional Failure

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the secondary containment system was not reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, while restoring the normal reactor building ventilation system to service following maintenance, reactor building-to-ambient differential pressure dropped below the Technical Specification (TS) required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. However, FitzPatrick staff did not promptly recognize this as a condition reportable under 10 CFR 50.72. As corrective action, FitzPatrick staff reported the condition to the NRC in accordance with 10 CFR 50.72 (b)(3)(v) and entered it into the corrective action program (CAP) as condition report (CR)-JAF-2014-06498.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably

within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2014005](#) (*pdf*)

Significance: G Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

TS Actions for Inoperable ECCS Not Performed Within the TS Allowed Completion Time

The inspectors identified a Green NCV for two violations of TS 3.5.1, "ECCS [emergency core cooling systems] - Operating," associated with the non-functionality of east crescent area ventilation and cooling (CAVC) subsystem unit cooler 66UC-22H. Specifically, during the periods May 5 through May 21, 2010, and March 15 through March 25, 2011, the Technical Requirements Manual (TRM) requirements for east crescent unit cooler operability were not satisfied for longer than the allowed outage time (AOT), which caused the ECCS in the east crescent to become inoperable and remain so for longer than the TS AOT without completion of the required plant mode changes. As immediate corrective action, Entergy personnel reconditioned the fan motor contactor for the affected unit cooler to obtain satisfactory low voltage pickup response. The issue was entered into Entergy's CAP as CR-JAF-2012-00584 and CR-JAF-2012-02288.

The finding was more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the unsatisfactory low voltage response of the 66UC-22H fan motor contactor, along with the unavailability of another east CAVC unit cooler due to maintenance, could have degraded the capability of ECCS systems in the east crescent area during an accident concurrent with degraded voltage conditions. In light of FitzPatrick staff's determination that there was reasonable assurance that the remaining three operable unit coolers would have been capable of removing required post-accident heat loads, the inspectors determined that the finding was of very low safety significance (Green) in accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS AOT, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Resolution, because FitzPatrick staff did not take effective corrective actions to address the low voltage pickup issue in a timely manner commensurate with its safety significance [P.3].

Inspection Report# : [2014005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Properly Ship RAM-QC

Green. The inspectors identified a Green NCV of 10 CFR 71.5, "Transportation of Licensed Material," and 49 CFR 172, Subpart I, "Safety and Security Plans." Specifically, Entergy personnel shipped a radioactive quantity of category 2 Radioactive Material in Quantities of Concern (RAM-QC) on the public highways to a waste processor without adhering to its transportation security plan. Prior to shipment, Entergy staff failed to recognize that the quantity of radioactive material met the definition of RAM-QC. Entergy staff entered this issue into their corrective action program (CAP) as condition report (CR) JAF 2014 02337.

The issue was more than minor because it was associated with the Program and Process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain. In accordance with IMC 0609, Appendix D, "Public Radiation Safety Significance Determination Process," the finding was determined to be of very low safety significance (Green) because Entergy had an issue involving transportation of radioactive material, but it did not involve: (1) a radiation limit exceeded; (2) a breach of package during transport; (3) a certificate of compliance issue; (4) a low level burial ground nonconformance; or (5) a failure to make notifications or provide emergency information. This finding had a cross-cutting aspect in the area of Human Performance, Work Processes, in that the documentation (procedures) to support this activity was inadequate [H.7]. (Section 2RS8)

Inspection Report# : [2014003](#) (*pdf*)

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A May 03, 2014

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. Entergy personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. Entergy staff appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Entergy typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Entergy staff adequately identified, reviewed, and applied relevant industry operating experience to FitzPatrick operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were thorough.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2014009](#) (*pdf*)

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : June 16, 2015

FitzPatrick 2Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Inadequate Preventive Maintenance Strategy and Test Procedure for RWR MG Resulted in Multiple Plant Transients

A self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," was identified for failure to institute appropriate processes and procedures for periodic maintenance activities of the reactor water recirculation motor generators (RWR MGs). During startup from refueling outage 21, degraded material conditions led to tripping of an RWR MG, with the resultant loss of the associated RWR pump and down power transient, on three occasions. Specifically, one trip was due to carbon dust buildup within the 'A' RWR MG exciter, and two trips were due to a high resistance connection between the 'B' RWR MG generator field winding and a slip ring.

Additionally, a fourth trip occurred during performance of an inadequately prepared RWR MG test procedure. As corrective action, the high resistance connection associated with the 'B' RWR MG was eliminated, voltage regulator tuning for the 'B' RWR MG was successfully completed, and temporary instrumentation was connected to both RWR MGs to monitor various key parameters pending the implementation of long term corrective actions. The RWR MG trips were entered into the corrective action program (CAP) through individual condition reports (CRs) that were subsequently consolidated under CR-JAF-2014-06258 for root cause evaluation (RCE).

The finding was more than minor because it was associated with the Equipment Performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the transient initiation of single RWR loop operations challenges the reactor feedwater and vessel level control systems such that a more significant plant transient could result, and challenges plant operators in establishing allowable single RWR loop operating conditions. In accordance with Inspection Manual Chapter (IMC) 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that the finding was of very low safety significance (Green) because the performance deficiency was a transient initiator that did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick staff did not ensure that procedures for RWR preventive maintenance and voltage regulator tuning were adequate to support nuclear safety (H.1).

Inspection Report# : [2015001](#) (*pdf*)

Significance: N/A Sep 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Notify NRC Within 30 Days of Medical Changes for Licensed Operators

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, on three occasions, Entergy staff did not notify the NRC of a change in the medical status of a licensed operator within 30 days of learning of the diagnosis. These issues were entered into the corrective action program (CAP) as condition report

(CR)-JAF-2014-02227 and CR-JAF-2014-02304.

The inspectors determined that Entergy's failure to notify the NRC of licensed operator medical status changes as described above within 30 days was a performance deficiency that was within Entergy's ability to foresee and correct and should have been prevented. Because the issue had the potential to affect the NRC's ability to perform its regulatory function, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.4.d.1(b) from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation because Entergy staff did not communicate licensed operator permanent medical status changes within the 30 day reporting requirement for three licensed operators. In accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2014004](#) (pdf)

Mitigating Systems

Significance: N/A Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of a Secondary Containment System Functional Failure

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the secondary containment system was not reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, while restoring the normal reactor building ventilation system to service following maintenance, reactor building-to-ambient differential pressure dropped below the Technical Specification (TS) required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. However, FitzPatrick staff did not promptly recognize this as a condition reportable under 10 CFR 50.72. As corrective action, FitzPatrick staff reported the condition to the NRC in accordance with 10 CFR 50.72 (b)(3)(v) and entered it into the corrective action program (CAP) as condition report (CR)-JAF-2014-06498.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2014005](#) (pdf)

Significance:  Dec 31, 2014
Identified By: NRC

Item Type: NCV Non-Cited Violation

TS Actions for Inoperable ECCS Not Performed Within the TS Allowed Completion Time

The inspectors identified a Green non-cited violation (NCV) for two violations of Technical Specification (TS) 3.5.1, "ECCS [emergency core cooling systems] - Operating," associated with the non-functionality of east crescent area ventilation and cooling (CAVC) subsystem unit cooler 66UC-22H. Specifically, during the periods May 5 through May 21, 2010, and March 15 through March 25, 2011, the Technical Requirements Manual (TRM) requirements for east crescent unit cooler operability were not satisfied for longer than the allowed outage time (AOT), which caused the ECCS in the east crescent to become inoperable and remain so for longer than the TS AOT without completion of the required plant mode changes. As immediate corrective action, Entergy personnel reconditioned the fan motor contactor for the affected unit cooler to obtain satisfactory low voltage pickup response. The issue was entered into Entergy's corrective action program (CAP) as condition report (CR)-JAF-2012-00584 and CR-JAF-2012-02288.

The finding was more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the unsatisfactory low voltage response of the 66UC-22H fan motor contactor, along with the unavailability of another east CAVC unit cooler due to maintenance, could have degraded the capability of ECCS systems in the east crescent area during an accident concurrent with degraded voltage conditions. In light of FitzPatrick staff's determination that there was reasonable assurance that the remaining three operable unit coolers would have been capable of removing required post-accident heat loads, the inspectors determined that the finding was of very low safety significance (Green) in accordance with Inspection Manual Chapter (IMC) 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS AOT, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Resolution, because FitzPatrick staff did not take effective corrective actions to address the low voltage pickup issue in a timely manner commensurate with its safety significance (P.3).

Inspection Report# : [2014005](#) (*pdf*)

Barrier Integrity

Significance: G Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Incomplete Fuel Support Piece Seating Not Identified During Post-Refueling Core Verification

A self-revealing, Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified because the existence of a partially seated fuel support piece at reactor cell location 38-39 was not identified when FitzPatrick staff performed the procedure for reactor core verification at the conclusion of refueling operations during the 2014 refueling outage (RO21). Specifically, the fact that the four fuel assemblies associated with cell 38-39 were elevated by an estimated 1.5 inches above the top of the rest of the fuel assemblies in the reactor core was not identified during visual verification of fuel assembly seating performed after the conclusion of core alterations in accordance with procedure EN-RE-210, "BWR [boiling water reactor] Reactor Core and MPC [multi-purpose canister] Cask Fuel Verification." As immediate corrective action, FitzPatrick staff engaged the fuel vendor, who provided an interim thermal limit penalty to be applied to the four affected fuel assemblies pending completion of a formal analysis. The issue was entered into FitzPatrick's corrective

action program (CAP) as condition report (CR)-JAF-2015-00789.

The finding was more than minor because it was associated with the Configuration Control attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the fuel support piece not being completely fitted into the top of the control rod guide tube resulted in increased bypass flow around the cell 38-39 fuel assemblies, which reduced the margin to thermal limits for these assemblies during normal, transient, and accident conditions. Since the performance deficiency associated with the finding occurred during shutdown operations and also had potential safety significance during normal at-power operations, the inspectors screened the finding for significance using both Inspection Manual Chapter (IMC) 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and IMC 0609 Appendix G, Attachment 1, "Shutdown Operations Significance Determination Process." The inspectors determined that the finding was of very low safety significance (Green) because the displaced fuel bundles did not have any negative impact on safety during shutdown conditions, and through application of a thermal limit penalty, did not negatively impact the safe operation of the reactor at power. This finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because FitzPatrick staff did not follow the procedure requirement for reactor core verification to verify that the tops of the fuel channels and bail handles were all at approximately the same height (H.8).

Inspection Report# : [2015001](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : August 07, 2015

FitzPatrick

3Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Inadequate Corrective Actions Result in Control Rod Drift and Reactor Power Reduction

A self-revealing NCV of Title 10 of the Code of Federal Regulations (10 CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified because FitzPatrick staff failed to correct a condition adverse to quality.

Specifically, Entergy failed to take effective corrective actions for condition report (CR)-JAF-2010-00287 to replace the control rod drive (CRD) hydraulic control unit (HCU) directional control valve (DCV) bolting material which had signs of corrosion after the same material was identified through operational experience as the cause of a control rod drift. As a result, on July 19, 2015, FitzPatrick control rod 10-07 drifted from the fully withdrawn to the fully inserted position in the reactor core leading to an immediate power reduction from 100 to 99 percent followed by a manual rapid power reduction to 56 percent. Entergy's subsequent corrective actions included an extent of condition review and completed or planned replacement of all susceptible directional control valve bolting.

The performance deficiency was determined to be more than minor because it was associated with the equipment performance attribute of the Initiating Events cornerstone, and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors determined that this finding was of very low safety significance (Green) using Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, because the finding did not cause both a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition (e.g. loss of condenser, loss of feed water). The inspectors determined that there was no cross-cutting aspect associated with this finding because the cause of the performance deficiency occurred more than three years ago, and was not representative of current plant performance.

Inspection Report# : [2015003](#) (*pdf*)

Significance: G Jun 26, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Adequately Assess the Impact of SRV Leakage on Operability

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) 50 Appendix B Criterion III, Design Control, associated with Fitzpatrick's failure to adequately assess and control the acceptance criteria specified in engineering analysis in EC-JAF-56258, "Operability Input for CR-JAF-2015-01271 SRV G Tailpipe Temperature Increase" which referenced JAF-RPT-03-0056 "Operational Leakage Action Levels for Target Rock Two-Stage Safety/Relief Valves." Fitzpatrick concluded that a 2-stage Target Rock Safety Relief Valve (SRV) was operable with pilot valve leakage provided the leak rate was less than 1000 lbm/hr. This conclusion was not adequately supported by the available industry and plant data on setpoint drift and the references provided. As a result, Fitzpatrick did not declare 2-stage Target Rock Pilot valves inoperable when the leak rate exceeded 600 lbm/hr in 2007 and 2009. Fitzpatrick entered this issue into the corrective action system (CR-JAF-2015-02850) and is

reassessing the appropriate operability criteria.

This performance deficiency is more than minor because it adversely affects the equipment performance attribute of the initiating events cornerstone in IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations by ensuring RCS barrier integrity. This finding screens to Green using IMC 0609, "Significance Determination Process," Attachment 4, "Initial Characterization of Findings," and IMC 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions," Section A, "LOCA Initiators," as the finding could not result in leakage exceeding that of a small break LOCA nor could it have resulted in an interfacing system LOCA. The inspectors determined that this performance deficiency had a cross-cutting aspect in human performance, conservative bias, where individuals use decision making-practices that emphasize prudent choices over those that are simply allowable. [H.14] Section 1R17.

Inspection Report# : [2015007](#) (pdf)

Significance: G Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Inadequate Preventive Maintenance Strategy and Test Procedure for RWR MG Resulted in Multiple Plant Transients

A self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," was identified for failure to institute appropriate processes and procedures for periodic maintenance activities of the reactor water recirculation motor generators (RWR MGs). During startup from refueling outage 21, degraded material conditions led to tripping of an RWR MG, with the resultant loss of the associated RWR pump and down power transient, on three occasions. Specifically, one trip was due to carbon dust buildup within the 'A' RWR MG exciter, and two trips were due to a high resistance connection between the 'B' RWR MG generator field winding and a slip ring.

Additionally, a fourth trip occurred during performance of an inadequately prepared RWR MG test procedure. As corrective action, the high resistance connection associated with the 'B' RWR MG was eliminated, voltage regulator tuning for the 'B' RWR MG was successfully completed, and temporary instrumentation was connected to both RWR MGs to monitor various key parameters pending the implementation of long term corrective actions. The RWR MG trips were entered into the corrective action program (CAP) through individual condition reports (CRs) that were subsequently consolidated under CR-JAF-2014-06258 for root cause evaluation (RCE).

The finding was more than minor because it was associated with the Equipment Performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the transient initiation of single RWR loop operations challenges the reactor feedwater and vessel level control systems such that a more significant plant transient could result, and challenges plant operators in establishing allowable single RWR loop operating conditions. In accordance with Inspection Manual Chapter (IMC) 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that the finding was of very low safety significance (Green) because the performance deficiency was a transient initiator that did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick staff did not ensure that procedures for RWR preventive maintenance and voltage regulator tuning were adequate to support nuclear safety (H.1).

Inspection Report# : [2015001](#) (pdf)

Mitigating Systems

Significance: N/A Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of a Secondary Containment System Functional Failure

The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the secondary containment system was not reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, while restoring the normal reactor building ventilation system to service following maintenance, reactor building-to-ambient differential pressure dropped below the Technical Specification (TS) required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. However, FitzPatrick staff did not promptly recognize this as a condition reportable under 10 CFR 50.72. As corrective action, FitzPatrick staff reported the condition to the NRC in accordance with 10 CFR 50.72 (b)(3)(v) and entered it into the corrective action program (CAP) as condition report (CR)-JAF-2014-06498.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2014005](#) (*pdf*)

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

TS Actions for Inoperable ECCS Not Performed Within the TS Allowed Completion Time

The inspectors identified a Green non-cited violation (NCV) for two violations of Technical Specification (TS) 3.5.1, "ECCS [emergency core cooling systems] - Operating," associated with the non-functionality of east crescent area ventilation and cooling (CAVC) subsystem unit cooler 66UC-22H. Specifically, during the periods May 5 through May 21, 2010, and March 15 through March 25, 2011, the Technical Requirements Manual (TRM) requirements for east crescent unit cooler operability were not satisfied for longer than the allowed outage time (AOT), which caused the ECCS in the east crescent to become inoperable and remain so for longer than the TS AOT without completion of the required plant mode changes. As immediate corrective action, Entergy personnel reconditioned the fan motor contactor for the affected unit cooler to obtain satisfactory low voltage pickup response. The issue was entered into Entergy's corrective action program (CAP) as condition report (CR)-JAF-2012-00584 and CR-JAF-2012-02288.

The finding was more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the unsatisfactory low voltage response of the 66UC-22H fan motor contactor, along with the unavailability of another

east CAVC unit cooler due to maintenance, could have degraded the capability of ECCS systems in the east crescent area during an accident concurrent with degraded voltage conditions. In light of FitzPatrick staff's determination that there was reasonable assurance that the remaining three operable unit coolers would have been capable of removing required post-accident heat loads, the inspectors determined that the finding was of very low safety significance (Green) in accordance with Inspection Manual Chapter (IMC) 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS AOT, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Resolution, because FitzPatrick staff did not take effective corrective actions to address the low voltage pickup issue in a timely manner commensurate with its safety significance (P.3).

Inspection Report# : [2014005](#) (pdf)

Barrier Integrity

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Instructions for Reactor Building Roof Relacement Result in Inadvertent Loss of Secondary Containment

The inspectors identified a self-revealing violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because FitzPatrick staff failed to provide instructions appropriate to the reactor building roof replacement project. Specifically, inadequate instructions were provided to ensure that roofing material removal would be performed in slow, deliberate manner, such that its effect on secondary containment could be assessed and operability maintained. As a result, this activity caused secondary containment to be inoperable for a period in excess of its four hour technical specification (TS) allowed outage time. As immediate corrective action, roofing material removal was stopped and the new roofing materials were installed to reseal the affected area of the reactor building roof. Secondary containment vacuum was restored to greater than the TS-required minimum after a period of 92 minutes and secondary containment was declared operable after a period of five hours and 26 minutes. The issue was entered into the corrective action program (CAP) as CR-JAF-2015-03260.

The finding was more than minor because it is associated with the procedure quality attribute of the Barrier Integrity cornerstone, and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system (RCS), and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the work order (WO) did not provide adequate instruction to ensure that roofing material removal would be performed in slow, deliberate manner, coordinated between operations and maintenance personnel, and allowing adequate time after actions that could impact secondary containment such that their effect on secondary containment could be assessed and operability maintained. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a pressurized thermal shock issue, did not represent an actual open pathway in the physical integrity of the reactor containment, did not involve an actual reduction in function of hydrogen igniters in the reactor containment, and only represented a degradation of the radiological barrier function provided by the reactor building and standby gas treatment system. The finding had a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because FitzPatrick staff did not adequately plan for the possibility of

latent issues and inherent risk associated with the reactor building roof replacement project, such that the commencement of work resulted in a loss of secondary containment [H.12].

Inspection Report# : [2015003](#) (*pdf*)

Significance: G Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Incomplete Fuel Support Piece Seating Not Identified During Post-Refueling Core Verification

A self-revealing, Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50 Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified because the existence of a partially seated fuel support piece at reactor cell location 38-39 was not identified when FitzPatrick staff performed the procedure for reactor core verification at the conclusion of refueling operations during the 2014 refueling outage (RO21). Specifically, the fact that the four fuel assemblies associated with cell 38-39 were elevated by an estimated 1.5 inches above the top of the rest of the fuel assemblies in the reactor core was not identified during visual verification of fuel assembly seating performed after the conclusion of core alterations in accordance with procedure EN-RE-210, “BWR [boiling water reactor] Reactor Core and MPC [multi-purpose canister] Cask Fuel Verification.” As immediate corrective action, FitzPatrick staff engaged the fuel vendor, who provided an interim thermal limit penalty to be applied to the four affected fuel assemblies pending completion of a formal analysis. The issue was entered into FitzPatrick’s corrective action program (CAP) as condition report (CR)-JAF-2015-00789.

The finding was more than minor because it was associated with the Configuration Control attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the fuel support piece not being completely fitted into the top of the control rod guide tube resulted in increased bypass flow around the cell 38-39 fuel assemblies, which reduced the margin to thermal limits for these assemblies during normal, transient, and accident conditions. Since the performance deficiency associated with the finding occurred during shutdown operations and also had potential safety significance during normal at-power operations, the inspectors screened the finding for significance using both Inspection Manual Chapter (IMC) 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” and IMC 0609 Appendix G, Attachment 1, “Shutdown Operations Significance Determination Process.” The inspectors determined that the finding was of very low safety significance (Green) because the displaced fuel bundles did not have any negative impact on safety during shutdown conditions, and through application of a thermal limit penalty, did not negatively impact the safe operation of the reactor at power. This finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because FitzPatrick staff did not follow the procedure requirement for reactor core verification to verify that the tops of the fuel channels and bail handles were all at approximately the same height (H.8).

Inspection Report# : [2015001](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : December 15, 2015

FitzPatrick 4Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Inadequate Corrective Actions Result in Control Rod Drift and Reactor Power Reduction

A self-revealing NCV of Title 10 of the Code of Federal Regulations (10 CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified because FitzPatrick staff failed to correct a condition adverse to quality. Specifically, Entergy failed to take effective corrective actions for condition report (CR)-JAF-2010-00287 to replace the control rod drive (CRD) hydraulic control unit (HCU) directional control valve (DCV) bolting material which had signs of corrosion after the same material was identified through operational experience as the cause of a control rod drift. As a result, on July 19, 2015, FitzPatrick control rod 10-07 drifted from the fully withdrawn to the fully inserted position in the reactor core leading to an immediate power reduction from 100 to 99 percent followed by a manual rapid power reduction to 56 percent. Entergy's subsequent corrective actions included an extent of condition review and completed or planned replacement of all susceptible directional control valve bolting.

The performance deficiency was determined to be more than minor because it was associated with the equipment performance attribute of the Initiating Events cornerstone, and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors determined that this finding was of very low safety significance (Green) using Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, because the finding did not cause both a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition (e.g. loss of condenser, loss of feed water). The inspectors determined that there was no cross-cutting aspect associated with this finding because the cause of the performance deficiency occurred more than three years ago, and was not representative of current plant performance.

Inspection Report# : [2015003](#) (*pdf*)

Significance: G Jun 26, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Adequately Assess the Impact of SRV Leakage on Operability

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) 50 Appendix B Criterion III, Design Control, associated with Fitzpatrick's failure to adequately assess and control the acceptance criteria specified in engineering analysis in EC-JAF-56258, "Operability Input for CR-JAF-2015-01271 SRV G Tailpipe Temperature Increase" which referenced JAF-RPT-03-0056 "Operational Leakage Action Levels for Target Rock Two-Stage Safety/Relief Valves." Fitzpatrick concluded that a 2-stage Target Rock Safety Relief Valve (SRV) was operable with pilot valve leakage provided the leak rate was less than 1000 lbm/hr. This conclusion was not adequately supported by the available industry and plant data on setpoint drift and the references provided. As a result, Fitzpatrick did not declare 2-stage Target Rock Pilot valves inoperable when the leak rate exceeded 600 lbm/hr in 2007 and 2009. Fitzpatrick entered this issue into the corrective action system (CR-JAF-2015-02850) and is

reassessing the appropriate operability criteria.

This performance deficiency is more than minor because it adversely affects the equipment performance attribute of the initiating events cornerstone in IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations by ensuring RCS barrier integrity. This finding screens to Green using IMC 0609, "Significance Determination Process," Attachment 4, "Initial Characterization of Findings," and IMC 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions," Section A, "LOCA Initiators," as the finding could not result in leakage exceeding that of a small break LOCA nor could it have resulted in an interfacing system LOCA. The inspectors determined that this performance deficiency had a cross-cutting aspect in human performance, conservative bias, where individuals use decision making-practices that emphasize prudent choices over those that are simply allowable. [H.14] Section 1R17.

Inspection Report# : [2015007](#) (*pdf*)

Significance: G Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Inadequate Preventive Maintenance Strategy and Test Procedure for RWR MG Resulted in Multiple Plant Transients

A self-revealing, Green non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," was identified for failure to institute appropriate processes and procedures for periodic maintenance activities of the reactor water recirculation motor generators (RWR MGs). During startup from refueling outage 21, degraded material conditions led to tripping of an RWR MG, with the resultant loss of the associated RWR pump and down power transient, on three occasions. Specifically, one trip was due to carbon dust buildup within the 'A' RWR MG exciter, and two trips were due to a high resistance connection between the 'B' RWR MG generator field winding and a slip ring. Additionally, a fourth trip occurred during performance of an inadequately prepared RWR MG test procedure. As corrective action, the high resistance connection associated with the 'B' RWR MG was eliminated, voltage regulator tuning for the 'B' RWR MG was successfully completed, and temporary instrumentation was connected to both RWR MGs to monitor various key parameters pending the implementation of long term corrective actions. The RWR MG trips were entered into the corrective action program (CAP) through individual condition reports (CRs) that were subsequently consolidated under CR-JAF-2014-06258 for root cause evaluation (RCE).

The finding was more than minor because it was associated with the Equipment Performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the transient initiation of single RWR loop operations challenges the reactor feedwater and vessel level control systems such that a more significant plant transient could result, and challenges plant operators in establishing allowable single RWR loop operating conditions. In accordance with Inspection Manual Chapter (IMC) 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that the finding was of very low safety significance (Green) because the performance deficiency was a transient initiator that did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick staff did not ensure that procedures for RWR preventive maintenance and voltage regulator tuning were adequate to support nuclear safety (H.1).

Inspection Report# : [2015001](#) (*pdf*)

Mitigating Systems

Significance:  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unintended Elevated Plant Risk During EDG Maintenance

The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.65, “Requirements for monitoring the effectiveness of maintenance at nuclear power plants,” for failure to adequately manage the increase in risk during planned maintenance on the ‘A’ emergency diesel generator (EDG). Specifically, Entergy staff action to make the ‘C’ EDG unavailable while the ‘A’ EDG was already unavailable resulted in an unplanned increase in overall plant risk and deviation from the approved EDG outage risk management plan from a risk category of Green to the next higher risk category of Yellow. As immediate corrective action, the issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2015-05242.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the ‘C’ EDG was not available when it should have been, in accordance with the approved risk management plan, which resulted in an unplanned escalation of risk from Green to Yellow. Additionally, this finding was similar to example 7.e in IMC 0612, Appendix E, “Examples of Minor Issues.” In accordance with IMC 0609.04, “Initial Characterization of Findings,” and Exhibit 2 of IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent actual loss of a safety function of a single train for greater than its Technical Specification (TS) allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Work Management, because FitzPatrick did not execute the ‘A’ EDG maintenance outage work activities as planned, and after deviating from that plan, did not identify and manage the risk of barring the ‘C’ EDG while the ‘A’ EDG was unavailable [H.5].
Inspection Report# : [2015004](#) (*pdf*)

Barrier Integrity

Significance: N/A Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of Inoperable Secondary Containment

The inspectors identified a Severity Level (SL) IV NCV of 10 CFR 50.72, “Immediate Notification Requirements for Operating Nuclear Power Reactors,” because inoperability of the secondary containment system was not reported to the NRC within eight hours of when the need to do so should reasonably have been recognized, as required by 10 CFR 50.72(b)(3)(v), “Event or Condition that Could Have Prevented Fulfillment of a Safety Function.” Specifically, positive pressure in the secondary containment due to a previously unidentified equipment malfunction that occurred during transition between the reactor building being isolated and normal reactor building ventilation being in service was not promptly recognized as a condition that caused the single train secondary containment system to be inoperable and therefore to be reportable under 10 CFR 50.72. This issue was entered into the CAP as CR-JAF-2015-05244 and CR-JAF-2015-05265.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability

within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using Example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was an SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2015004](#) (pdf)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Instructions for Reactor Building Roof Relacement Result in Inadvertent Loss of Secondary Containment

The inspectors identified a self-revealing violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because FitzPatrick staff failed to provide instructions appropriate to the reactor building roof replacement project. Specifically, inadequate instructions were provided to ensure that roofing material removal would be performed in slow, deliberate manner, such that its effect on secondary containment could be assessed and operability maintained. As a result, this activity caused secondary containment to be inoperable for a period in excess of its four hour technical specification (TS) allowed outage time. As immediate corrective action, roofing material removal was stopped and the new roofing materials were installed to reseal the affected area of the reactor building roof. Secondary containment vacuum was restored to greater than the TS-required minimum after a period of 92 minutes and secondary containment was declared operable after a period of five hours and 26 minutes. The issue was entered into the corrective action program (CAP) as CR-JAF-2015-03260.

The finding was more than minor because it is associated with the procedure quality attribute of the Barrier Integrity cornerstone, and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system (RCS), and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the work order (WO) did not provide adequate instruction to ensure that roofing material removal would be performed in slow, deliberate manner, coordinated between operations and maintenance personnel, and allowing adequate time after actions that could impact secondary containment such that their effect on secondary containment could be assessed and operability maintained. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a pressurized thermal shock issue, did not represent an actual open pathway in the physical integrity of the reactor containment, did not involve an actual reduction in function of hydrogen igniters in the reactor containment, and only represented a degradation of the radiological barrier function provided by the reactor building and standby gas treatment system. The finding had a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because FitzPatrick staff did not adequately plan for the possibility of latent issues and inherent risk associated with the reactor building roof replacement project, such that the commencement of work resulted in a loss of secondary containment [H.12].

Inspection Report# : [2015003](#) (pdf)

Significance:  Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Incomplete Fuel Support Piece Seating Not Identified During Post-Refueling Core Verification

A self-revealing, Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50 Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified because the existence of a partially seated fuel support piece at reactor cell location 38-39 was not identified when FitzPatrick staff performed the procedure for reactor core verification at the conclusion of refueling operations during the 2014 refueling outage (RO21). Specifically, the fact that the four fuel assemblies associated with cell 38-39 were elevated by an estimated 1.5 inches above the top of the rest of the fuel assemblies in the reactor core was not identified during visual verification of fuel assembly seating performed after the conclusion of core alterations in accordance with procedure EN-RE-210, “BWR [boiling water reactor] Reactor Core and MPC [multi-purpose canister] Cask Fuel Verification.” As immediate corrective action, FitzPatrick staff engaged the fuel vendor, who provided an interim thermal limit penalty to be applied to the four affected fuel assemblies pending completion of a formal analysis. The issue was entered into FitzPatrick’s corrective action program (CAP) as condition report (CR)-JAF-2015-00789.

The finding was more than minor because it was associated with the Configuration Control attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the fuel support piece not being completely fitted into the top of the control rod guide tube resulted in increased bypass flow around the cell 38-39 fuel assemblies, which reduced the margin to thermal limits for these assemblies during normal, transient, and accident conditions. Since the performance deficiency associated with the finding occurred during shutdown operations and also had potential safety significance during normal at-power operations, the inspectors screened the finding for significance using both Inspection Manual Chapter (IMC) 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” and IMC 0609 Appendix G, Attachment 1, “Shutdown Operations Significance Determination Process.” The inspectors determined that the finding was of very low safety significance (Green) because the displaced fuel bundles did not have any negative impact on safety during shutdown conditions, and through application of a thermal limit penalty, did not negatively impact the safe operation of the reactor at power. This finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because FitzPatrick staff did not follow the procedure requirement for reactor core verification to verify that the tops of the fuel channels and bail handles were all at approximately the same height (H.8).

Inspection Report# : [2015001](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission

has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : March 01, 2016

FitzPatrick 1Q/2016 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Inadequate Corrective Actions Result in Control Rod Drift and Reactor Power Reduction

A self-revealing NCV of Title 10 of the Code of Federal Regulations (10 CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified because FitzPatrick staff failed to correct a condition adverse to quality. Specifically, Entergy failed to take effective corrective actions for condition report (CR)-JAF-2010-00287 to replace the control rod drive (CRD) hydraulic control unit (HCU) directional control valve (DCV) bolting material which had signs of corrosion after the same material was identified through operational experience as the cause of a control rod drift. As a result, on July 19, 2015, FitzPatrick control rod 10-07 drifted from the fully withdrawn to the fully inserted position in the reactor core leading to an immediate power reduction from 100 to 99 percent followed by a manual rapid power reduction to 56 percent. Entergy's subsequent corrective actions included an extent of condition review and completed or planned replacement of all susceptible directional control valve bolting.

The performance deficiency was determined to be more than minor because it was associated with the equipment performance attribute of the Initiating Events cornerstone, and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors determined that this finding was of very low safety significance (Green) using Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, because the finding did not cause both a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition (e.g. loss of condenser, loss of feed water). The inspectors determined that there was no cross-cutting aspect associated with this finding because the cause of the performance deficiency occurred more than three years ago, and was not representative of current plant performance.

Inspection Report# : [2015003](#) (*pdf*)

Significance: G Jun 26, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Adequately Assess the Impact of SRV Leakage on Operability

The inspectors identified a Green non-cited violation (NCV) of Title 10 of the Code of Federal Regulations (10 CFR) 50 Appendix B Criterion III, Design Control, associated with Fitzpatrick's failure to adequately assess and control the acceptance criteria specified in engineering analysis in EC-JAF-56258, "Operability Input for CR-JAF-2015-01271 SRV G Tailpipe Temperature Increase" which referenced JAF-RPT-03-0056 "Operational Leakage Action Levels for Target Rock Two-Stage Safety/Relief Valves." Fitzpatrick concluded that a 2-stage Target Rock Safety Relief Valve (SRV) was operable with pilot valve leakage provided the leak rate was less than 1000 lbm/hr. This conclusion was not adequately supported by the available industry and plant data on setpoint drift and the references provided. As a result, Fitzpatrick did not declare 2-stage Target Rock Pilot valves inoperable when the leak rate exceeded 600 lbm/hr in 2007 and 2009. Fitzpatrick entered this issue into the corrective action system (CR-JAF-2015-02850) and is

reassessing the appropriate operability criteria.

This performance deficiency is more than minor because it adversely affects the equipment performance attribute of the initiating events cornerstone in IMC 0612, “Power Reactor Inspection Reports,” Appendix B, “Issue Screening,” to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations by ensuring RCS barrier integrity. This finding screens to Green using IMC 0609, “Significance Determination Process,” Attachment 4, “Initial Characterization of Findings,” and IMC 0609, Appendix A, Exhibit 1, “Initiating Events Screening Questions,” Section A, “LOCA Initiators,” as the finding could not result in leakage exceeding that of a small break LOCA nor could it have resulted in an interfacing system LOCA. The inspectors determined that this performance deficiency had a cross-cutting aspect in human performance, conservative bias, where individuals use decision making-practices that emphasize prudent choices over those that are simply allowable. [H.14] Section 1R17.

Inspection Report# : [2015007](#) (*pdf*)

Mitigating Systems

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

[DRAFT] Unintended HPCI Pump Suction Transfer during Pressure Control Mode Operation

[DRAFT] The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for failure to maintain a condition specified in an emergency operating procedure. Specifically, while operating the high pressure coolant injection (HPCI) system in the pressure control mode, operators failed to override automatic transfer of the HPCI pump suction from the condensate storage tank (CST) to the suppression pool prior to the transfer actually occurring. As a result, operators had to revert to using the safety/relief valves (S/RVs) for pressure control, which introduced additional, unnecessary plant challenges. As immediate corrective action, operators secured HPCI, overrode the automatic HPCI pump suction transfer, realigned the pump suction to the CST, and restarted HPCI in the pressure control mode. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2016-00765.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the operators’ failure to timely override automatic transfer of the HPCI suction to the suppression pool resulted in an additional, avoidable post-scrum pressure and level transient being placed on the reactor pressure vessel (RPV) and unnecessarily reduced the thermal capacity of the suppression pool. In accordance with IMC 0609.04, “Initial Characterization of Findings,” and Exhibit 2 of IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of a safety function of a single train for greater than its technical specification (TS) allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because operators did not follow guidance of EOP-2 for the HPCI pump suction to be aligned to the CST by bypassing the HPCI pump suction swap to the suppression pool in a timely manner, such that the swap actually occurred (H.8).

Inspection Report# : [2016001](#) (*pdf*)

Significance: G Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

[DRAFT] Uncontrolled RPV Level Increase after Initiation of RHR Shutdown Cooling

[DRAFT] The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for failure to take actions specified in the procedure for initiation of shutdown cooling. Specifically, prior to placing the ‘A’ loop of the residual heat removal (RHR) system into shutdown cooling, an operator was not stationed to close the condensate transfer system cross-connect valve to the ‘A’ RHR loop (10RHR 274), nor was the valve immediately closed after initiation of shutdown cooling, as specified by the operating procedure. This resulted in a significant loss of operational control, in that RPV level increased to the point of putting water down the main steam lines. As immediate corrective action, operators closed 10RHR-274, thus stopping the RPV inventory increase. The issue was entered into the CAP as CR JAF 2016 00273.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the resultant loss of RPV level control represented a significant loss of operational control that could have affected the operability of the HPCI and reactor core isolation cooling (RCIC) systems, as well as the S/RVs, had their use again been required in the near term. In accordance with IMC 0609.04, “Initial Characterization of Findings,” and Exhibit 2 of IMC 0609, Appendix A, “The Significance Determination Process for Findings At Power,” the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because operators did not stop when faced with uncertain conditions. Specifically, without otherwise having maintained status control on the condensate transfer system cross-connect valve to the ‘A’ RHR loop, operators did not stop to positively establish the condition of the valve when it appeared in a conditional step in the procedure (that is, “if 10RHR-274 is open, then station an operator at 10RHR-274”) (H.11).

Inspection Report# : [2016001](#) (*pdf*)

Significance: G Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unintended Elevated Plant Risk During EDG Maintenance

The inspectors identified a Green NCV of Title10 of the Code of Federal Regulations (10 CFR) 50.65, “Requirements for monitoring the effectiveness of maintenance at nuclear power plants,” for failure to adequately manage the increase in risk during planned maintenance on the ‘A’ emergency diesel generator (EDG). Specifically, Entergy staff action to make the ‘C’ EDG unavailable while the ‘A’ EDG was already unavailable resulted in an unplanned increase in overall plant risk and deviation from the approved EDG outage risk management plan from a risk category of Green to the next higher risk category of Yellow. As immediate corrective action, the issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2015-05242.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the ‘C’ EDG was not available when it should have been, in accordance with the approved risk management plan, which resulted in an unplanned escalation of risk from Green to Yellow. Additionally, this finding was similar to example 7.e in IMC 0612, Appendix E, “Examples of Minor Issues.” In accordance with IMC 0609.04, “Initial Characterization of Findings,” and Exhibit 2 of IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-

Power,” the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent actual loss of a safety function of a single train for greater than its Technical Specification (TS) allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Work Management, because FitzPatrick did not execute the ‘A’ EDG maintenance outage work activities as planned, and after deviating from that plan, did not identify and manage the risk of barring the ‘C’ EDG while the ‘A’ EDG was unavailable [H.5].
Inspection Report# : [2015004](#) (*pdf*)

Barrier Integrity

Significance: G Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

[DRAFT] Inadequate Post-Maintenance Testing of the Reactor Building Ventilation System Resulted in Short-Term Inoperability of Secondary Containment

[DRAFT] The inspectors identified a self-revealing NCV of TS 5.4, “Procedures,” for FitzPatrick staff’s failure to perform adequate post-maintenance testing (PMT) following maintenance on a limit switch in the reactor building ventilation system in August 2014, that, along with another unrelated component failure in the reactor building ventilation system, resulted in secondary containment pressure, relative to the outside pressure, exceeding the TS limit of 0.25 inches of vacuum water gauge. As immediate corrective action, operators started both trains of the standby gas treatment system (SBGTS), which restored secondary containment pressure to within the TS limit. Operators subsequently secured the ‘A’ refuel floor exhaust train and placed the ‘B’ train in service. The issue was entered into the CAP as CR-JAF-2015-04166.

The finding was more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, as a result of this event, secondary containment was not preserved, in that secondary containment pressure exceeded the limit of TS surveillance requirement (SR) 3.6.4.1.1. In accordance with IMC 0609.04, “Initial Characterization of Findings,” and Exhibit 3 of IMC 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a pressurized thermal shock issue, did not represent an actual open pathway in the physical integrity of the reactor containment, did not involve an actual reduction in function of hydrogen igniters in the reactor containment, and only represented a degradation of the radiological barrier function provided by the reactor building and SBGTS. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick staff did not ensure that procedures for PMT of the reactor building refuel floor exhaust damper limit switch following maintenance performed in August 2014, were adequate to support the nuclear safety function of the secondary containment (H.1).

Inspection Report# : [2016001](#) (*pdf*)

Significance: N/A Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

[DRAFT] Untimely 10 CFR 50.72 Notification of Inoperable Secondary Containment

[DRAFT] The inspectors identified a SL IV NCV of 10 CFR 50.72, “Immediate Notification Requirements for Operating Nuclear Power Reactors,” because unplanned inoperability of the secondary containment system was not

reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), “Event or Condition That Could Have Prevented Fulfillment of a Safety Function.” Specifically, following reasonable resolution of questions regarding the reliability of secondary containment differential pressure (d/p) instrumentation indications, FitzPatrick staff did not promptly report that, during a transfer from normal reactor building ventilation in service to the reactor building being isolated with the SBGTS in service, reactor building d/p briefly dropped below the TS required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. As immediate corrective action, the event was reported to the NRC in accordance with 10 CFR 50.72(b)(3)(v). The issue was entered into the CAP as CR-JAF-2015-05244 and CR JAF 2015-05265.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy’s ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC’s opportunity to review the matter. Using Example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, “Power Reactor Inspection Reports,” traditional enforcement issues are not assigned cross-cutting aspects. Inspection Report# : [2016001](#) (*pdf*)

Significance: N/A Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of Inoperable Secondary Containment

The inspectors identified a Severity Level (SL) IV NCV of 10 CFR 50.72, “Immediate Notification Requirements for Operating Nuclear Power Reactors,” because inoperability of the secondary containment system was not reported to the NRC within eight hours of when the need to do so should reasonably have been recognized, as required by 10 CFR 50.72(b)(3)(v), “Event or Condition that Could Have Prevented Fulfillment of a Safety Function.” Specifically, positive pressure in the secondary containment due to a previously unidentified equipment malfunction that occurred during transition between the reactor building being isolated and normal reactor building ventilation being in service was not promptly recognized as a condition that caused the single train secondary containment system to be inoperable and therefore to be reportable under 10 CFR 50.72. This issue was entered into the CAP as CR-JAF-2015-05244 and CR-JAF-2015-05265.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy’s ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC’s opportunity to review the matter. Using Example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was an SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, “Power Reactor Inspection Reports,” traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2015004](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Instructions for Reactor Building Roof Relacement Result in Inadvertent Loss of Secondary Containment

The inspectors identified a self-revealing violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because FitzPatrick staff failed to provide instructions appropriate to the reactor building roof replacement project. Specifically, inadequate instructions were provided to ensure that roofing material removal would be performed in slow, deliberate manner, such that its effect on secondary containment could be assessed and operability maintained. As a result, this activity caused secondary containment to be inoperable for a period in excess of its four hour technical specification (TS) allowed outage time. As immediate corrective action, roofing material removal was stopped and the new roofing materials were installed to reseal the affected area of the reactor building roof. Secondary containment vacuum was restored to greater than the TS-required minimum after a period of 92 minutes and secondary containment was declared operable after a period of five hours and 26 minutes. The issue was entered into the corrective action program (CAP) as CR-JAF-2015-03260.

The finding was more than minor because it is associated with the procedure quality attribute of the Barrier Integrity cornerstone, and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system (RCS), and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the work order (WO) did not provide adequate instruction to ensure that roofing material removal would be performed in slow, deliberate manner, coordinated between operations and maintenance personnel, and allowing adequate time after actions that could impact secondary containment such that their effect on secondary containment could be assessed and operability maintained. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a pressurized thermal shock issue, did not represent an actual open pathway in the physical integrity of the reactor containment, did not involve an actual reduction in function of hydrogen igniters in the reactor containment, and only represented a degradation of the radiological barrier function provided by the reactor building and standby gas treatment system. The finding had a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because FitzPatrick staff did not adequately plan for the possibility of latent issues and inherent risk associated with the reactor building roof replacement project, such that the commencement of work resulted in a loss of secondary containment [H.12].

Inspection Report# : [2015003](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : July 11, 2016

FitzPatrick 2Q/2016 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Inadequate Corrective Actions Result in Control Rod Drift and Reactor Power Reduction

A self-revealing NCV of Title 10 of the Code of Federal Regulations (10 CFR) Part 50, Appendix B, Criterion XVI, “Corrective Action,” was identified because FitzPatrick staff failed to correct a condition adverse to quality. Specifically, Entergy failed to take effective corrective actions for condition report (CR)-JAF-2010-00287 to replace the control rod drive (CRD) hydraulic control unit (HCU) directional control valve (DCV) bolting material which had signs of corrosion after the same material was identified through operational experience as the cause of a control rod drift. As a result, on July 19, 2015, FitzPatrick control rod 10-07 drifted from the fully withdrawn to the fully inserted position in the reactor core leading to an immediate power reduction from 100 to 99 percent followed by a manual rapid power reduction to 56 percent. Entergy’s subsequent corrective actions included an extent of condition review and completed or planned replacement of all susceptible directional control valve bolting.

The performance deficiency was determined to be more than minor because it was associated with the equipment performance attribute of the Initiating Events cornerstone, and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors determined that this finding was of very low safety significance (Green) using Exhibit 1 of IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” dated June 19, 2012, because the finding did not cause both a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition (e.g. loss of condenser, loss of feed water). The inspectors determined that there was no cross-cutting aspect associated with this finding because the cause of the performance deficiency occurred more than three years ago, and was not representative of current plant performance.

Inspection Report# : [2015003](#) (*pdf*)

Mitigating Systems

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unintended HPCI Pump Suction Transfer during Pressure Control Mode Operation

The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for failure to maintain a condition specified in an emergency operating procedure. Specifically, while operating the high pressure coolant injection (HPCI) system in the pressure control mode, operators failed to override automatic transfer of the HPCI pump suction from the condensate storage tank (CST) to the suppression pool prior to the transfer actually occurring. As a result, operators had to revert to using

the safety/relief valves (S/RVs) for pressure control, which introduced additional, unnecessary plant challenges. As immediate corrective action, operators secured HPCI, overrode the automatic HPCI pump suction transfer, realigned the pump suction to the CST, and restarted HPCI in the pressure control mode. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2016-00765.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the operators' failure to timely override automatic transfer of the HPCI suction to the suppression pool resulted in an additional, avoidable post-scrum pressure and level transient being placed on the reactor pressure vessel (RPV) and unnecessarily reduced the thermal capacity of the suppression pool. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of a safety function of a single train for greater than its technical specification (TS) allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because operators did not follow guidance of EOP-2 for the HPCI pump suction to be aligned to the CST by bypassing the HPCI pump suction swap to the suppression pool in a timely manner, such that the swap actually occurred (H.8).

Inspection Report# : [2016001](#) (pdf)

G

Significance: Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Uncontrolled RPV Level Increase after Initiation of RHR Shutdown Cooling

The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for failure to take actions specified in the procedure for initiation of shutdown cooling. Specifically, prior to placing the 'A' loop of the residual heat removal (RHR) system into shutdown cooling, an operator was not stationed to close the condensate transfer system cross-connect valve to the 'A' RHR loop (10RHR 274), nor was the valve immediately closed after initiation of shutdown cooling, as specified by the operating procedure. This resulted in a significant loss of operational control, in that RPV level increased to the point of putting water down the main steam lines. As immediate corrective action, operators closed 10RHR-274, thus stopping the RPV inventory increase. The issue was entered into the CAP as CR JAF 2016 00273.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the resultant loss of RPV level control represented a significant loss of operational control that could have affected the operability of the HPCI and reactor core isolation cooling (RCIC) systems, as well as the S/RVs, had their use again been required in the near term. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because operators did not stop when faced with uncertain conditions. Specifically, without otherwise having maintained status control on the condensate transfer system cross-connect valve to the 'A' RHR loop, operators did not stop to positively establish the condition of the valve when it appeared in a conditional step in the procedure (that is, "if 10RHR-274 is open, then station an operator at 10RHR-274") (H.11).

Inspection Report# : [2016001](#) (pdf)

Significance:  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unintended Elevated Plant Risk During EDG Maintenance

The inspectors identified a Green NCV of Title10 of the Code of Federal Regulations (10 CFR) 50.65, “Requirements for monitoring the effectiveness of maintenance at nuclear power plants,” for failure to adequately manage the increase in risk during planned maintenance on the ‘A’ emergency diesel generator (EDG). Specifically, Entergy staff action to make the ‘C’ EDG unavailable while the ‘A’ EDG was already unavailable resulted in an unplanned increase in overall plant risk and deviation from the approved EDG outage risk management plan from a risk category of Green to the next higher risk category of Yellow. As immediate corrective action, the issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2015-05242.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the ‘C’ EDG was not available when it should have been, in accordance with the approved risk management plan, which resulted in an unplanned escalation of risk from Green to Yellow. Additionally, this finding was similar to example 7.e in IMC 0612, Appendix E, “Examples of Minor Issues.” In accordance with IMC 0609.04, “Initial Characterization of Findings,” and Exhibit 2 of IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent actual loss of a safety function of a single train for greater than its Technical Specification (TS) allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Work Management, because FitzPatrick did not execute the ‘A’ EDG maintenance outage work activities as planned, and after deviating from that plan, did not identify and manage the risk of barring the ‘C’ EDG while the ‘A’ EDG was unavailable [H.5].
Inspection Report# : [2015004](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Post-Maintenance Testing of the Reactor Building Ventilation System Resulted in Short-Term Inoperability of Secondary Containment

The inspectors identified a self-revealing NCV of TS 5.4, “Procedures,” for FitzPatrick staff’s failure to perform adequate post-maintenance testing (PMT) following maintenance on a limit switch in the reactor building ventilation system in August 2014, that, along with another unrelated component failure in the reactor building ventilation system, resulted in secondary containment pressure, relative to the outside pressure, exceeding the TS limit of 0.25 inches of vacuum water gauge. As immediate corrective action, operators started both trains of the standby gas treatment system (SBGTS), which restored secondary containment pressure to within the TS limit. Operators subsequently secured the ‘A’ refuel floor exhaust train and placed the ‘B’ train in service. The issue was entered into the CAP as CR-JAF-2015-04166.

The finding was more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused

by accidents or events. Specifically, as a result of this event, secondary containment was not preserved, in that secondary containment pressure exceeded the limit of TS surveillance requirement (SR) 3.6.4.1.1. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a pressurized thermal shock issue, did not represent an actual open pathway in the physical integrity of the reactor containment, did not involve an actual reduction in function of hydrogen igniters in the reactor containment, and only represented a degradation of the radiological barrier function provided by the reactor building and SBGTS. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick staff did not ensure that procedures for PMT of the reactor building refuel floor exhaust damper limit switch following maintenance performed in August 2014, were adequate to support the nuclear safety function of the secondary containment (H.1).

Inspection Report# : [2016001](#) (*pdf*)

Significance: N/A Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of Inoperable Secondary Containment

The inspectors identified a SL IV NCV of 10 CFR 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the secondary containment system was not reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition That Could Have Prevented Fulfillment of a Safety Function." Specifically, following reasonable resolution of questions regarding the reliability of secondary containment differential pressure (d/p) instrumentation indications, FitzPatrick staff did not promptly report that, during a transfer from normal reactor building ventilation in service to the reactor building being isolated with the SBGTS in service, reactor building d/p briefly dropped below the TS required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. As immediate corrective action, the event was reported to the NRC in accordance with 10 CFR 50.72(b)(3)(v). The issue was entered into the CAP as CR-JAF-2015-05244 and CR JAF 2015-05265.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using Example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects. Inspection Report# : [2016001](#) (*pdf*)

Significance: N/A Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of Inoperable Secondary Containment

The inspectors identified a Severity Level (SL) IV NCV of 10 CFR 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because inoperability of the secondary containment system was not reported to the NRC within eight hours of when the need to do so should reasonably have been recognized, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, positive pressure in the secondary containment due to a previously unidentified equipment malfunction that occurred during transition between the reactor building being isolated and normal reactor building ventilation being in service was not promptly recognized as a condition that caused the single train secondary containment system to be

inoperable and therefore to be reportable under 10 CFR 50.72. This issue was entered into the CAP as CR-JAF-2015-05244 and CR-JAF-2015-05265.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using Example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was an SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2015004](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Instructions for Reactor Building Roof Relacement Result in Inadvertent Loss of Secondary Containment

The inspectors identified a self-revealing violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because FitzPatrick staff failed to provide instructions appropriate to the reactor building roof replacement project. Specifically, inadequate instructions were provided to ensure that roofing material removal would be performed in slow, deliberate manner, such that its effect on secondary containment could be assessed and operability maintained. As a result, this activity caused secondary containment to be inoperable for a period in excess of its four hour technical specification (TS) allowed outage time. As immediate corrective action, roofing material removal was stopped and the new roofing materials were installed to reseal the affected area of the reactor building roof. Secondary containment vacuum was restored to greater than the TS-required minimum after a period of 92 minutes and secondary containment was declared operable after a period of five hours and 26 minutes. The issue was entered into the corrective action program (CAP) as CR-JAF-2015-03260.

The finding was more than minor because it is associated with the procedure quality attribute of the Barrier Integrity cornerstone, and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system (RCS), and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the work order (WO) did not provide adequate instruction to ensure that roofing material removal would be performed in slow, deliberate manner, coordinated between operations and maintenance personnel, and allowing adequate time after actions that could impact secondary containment such that their effect on secondary containment could be assessed and operability maintained. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a pressurized thermal shock issue, did not represent an actual open pathway in the physical integrity of the reactor containment, did not involve an actual reduction in function of hydrogen igniters in the reactor containment, and only represented a degradation of the radiological barrier function provided by the reactor building and standby gas treatment system. The finding had a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because FitzPatrick staff did not adequately plan for the possibility of latent issues and inherent risk associated with the reactor building roof replacement project, such that the commencement of work resulted in a loss of secondary containment [H.12].

Inspection Report# : [2015003](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

[DRAFT]Failure to Determine Dose Rates Prior to Entering a High Radiation Area (Section 2RS1)

[DRAFT]The inspectors identified a self-revealing, Green NCV of technical specification (TS) 5.7.1, “High Radiation Area.” Specifically, on January 24 and 25, 2016, operations personnel failed to notify the Radiation Protection (RP) department and non-licensed operators in the field when operating plant equipment, which created high radiation areas (HRAs). These areas therefore were not surveyed by RP to determine dose rates prior to non-licensed operators entering the areas. Personnel entry into HRAs without knowledge of the current dose rates is a performance deficiency. In both instances, RP evaluated the operators’ dose, validated the dosimeter alarms, surveyed both areas in response to the dose rate alarms, and reposted the areas as HRAs. Entergy documented the events in condition reports (CR)-JAF-2016-00269 and CR-JAF-2016-00369

The finding was more than minor because it resulted in the unintended exposure of two workers and affected the Occupational Radiation Safety cornerstone attribute of program and process associated with exposure/contamination controls and if left uncorrected could result in more significant exposures. The finding was determined to be of very low safety significance (Green) because it was not related to as low as is reasonably achievable (ALARA), did not result in an overexposure or a substantial potential for overexposure, and did not compromise the licensee’s ability to assess dose. A cross-cutting aspect of Human Performance, Teamwork, was associated with this finding. Specifically, licensed operators did not communicate to RP or non-licensed operators in the field when operating plant equipment which caused plant radiological conditions to change.

Inspection Report# : [2016002](#) (*pdf*)

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

[DRAFT]Failure to Conduct Operations to Minimize the Introduction of Residual Radioactivity to the Site (Section 2RS8)

[DRAFT]The NRC identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 20.1406(c) due to Entergy not conducting operations to minimize the introduction of residual radioactivity into the site. For at least the past four years, Entergy allowed leakage of the solid radwaste processing system to occur resulting in spilled radioactive waste which accumulated and remained on the floor of the filter sludge tank room in the radwaste building. The failure to remove the accumulated solid radioactive waste is a performance deficiency. Entergy entered this issue into their corrective action program (CAP) as CR-JAF-2016-01784 with actions to characterize the extent of residual radioactivity and evaluate cleanup actions.

This issue is more than minor because it is associated with the program and process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure the licensee’s ability to prevent inadvertent release and/or loss of control of licensed material. The finding had a cross-cutting aspect in the area of Problem Identification

and Resolution, Resolution, in that the condition was known to exist for over four years, impacted the radwaste system effectiveness to process solid radwaste, and had not been corrected.

Inspection Report# : [2016002](#) (*pdf*)

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : August 29, 2016

FitzPatrick 3Q/2016 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2016

Identified By: Self-Revealing

Item Type: FIN Finding

DRAFT Inadequate Preventive Maintenance Results In Transformer Failure and Reactor Scram

DRAFT A self-revealing Green finding (FIN) was identified for Entergy staff's failure to properly implement the requirements of EN-DC-324, "Preventive Maintenance Program," Revision 16, to ensure proper preventive maintenance (PM) was implemented for non-safety-related 4KV transformer 71T-5. Specifically, Action Request (AR) 127566, PM change request to perform inspection, cleaning, and electrical testing of 4KV transformer 71T-5 was retired without a review by engineering as required by the PM program. As a result, transformer 71T-5 remained in service beyond its effective life without proper condition monitoring and maintenance, leading to its failure and a reactor scram on June 24, 2016. Entergy staff developed corrective actions to address the failure which included replacement of the transformer and re-establishing the condition monitoring and PM task. Entergy also performed an extent of condition review that confirmed the PM to clean, inspect, and test similar non-safety-related dry-type transformers was still active and performed within its required frequency.

This finding is more than minor because it is associated with the Equipment Performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Specifically, Entergy staff failed to ensure an adequate PM was in place for transformer 71T-5. The PM to ensure adequate cleaning and testing was cancelled in 2011, and transformer 71T-5 ultimately failed on June 24, 2016, resulting in a manual reactor scram. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because although the performance deficiency caused a reactor scram, it did not result in the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The inspectors did not assign a cross-cutting aspect to this finding because it is not indicative of current licensee performance. Specifically, the performance deficiency was determined to have occurred in 2011, the guidance in EN-DC-324 is clear regarding the PM change process, and no additional failures to follow the process have resulted in significant reactor transients.

Inspection Report# : [2016003](#) (*pdf*)

Mitigating Systems

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unintended HPCI Pump Suction Transfer during Pressure Control Mode Operation

The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50, Appendix B,

Criterion V, "Instructions, Procedures, and Drawings," for failure to maintain a condition specified in an emergency operating procedure. Specifically, while operating the high pressure coolant injection (HPCI) system in the pressure control mode, operators failed to override automatic transfer of the HPCI pump suction from the condensate storage tank (CST) to the suppression pool prior to the transfer actually occurring. As a result, operators had to revert to using the safety/relief valves (S/RVs) for pressure control, which introduced additional, unnecessary plant challenges. As immediate corrective action, operators secured HPCI, overrode the automatic HPCI pump suction transfer, realigned the pump suction to the CST, and restarted HPCI in the pressure control mode. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2016-00765.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the operators' failure to timely override automatic transfer of the HPCI suction to the suppression pool resulted in an additional, avoidable post-scrum pressure and level transient being placed on the reactor pressure vessel (RPV) and unnecessarily reduced the thermal capacity of the suppression pool. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of a safety function of a single train for greater than its technical specification (TS) allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because operators did not follow guidance of EOP-2 for the HPCI pump suction to be aligned to the CST by bypassing the HPCI pump suction swap to the suppression pool in a timely manner, such that the swap actually occurred (H.8).

Inspection Report# : [2016001](#) (pdf)

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Uncontrolled RPV Level Increase after Initiation of RHR Shutdown Cooling

The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for failure to take actions specified in the procedure for initiation of shutdown cooling. Specifically, prior to placing the 'A' loop of the residual heat removal (RHR) system into shutdown cooling, an operator was not stationed to close the condensate transfer system cross-connect valve to the 'A' RHR loop (10RHR 274), nor was the valve immediately closed after initiation of shutdown cooling, as specified by the operating procedure. This resulted in a significant loss of operational control, in that RPV level increased to the point of putting water down the main steam lines. As immediate corrective action, operators closed 10RHR-274, thus stopping the RPV inventory increase. The issue was entered into the CAP as CR JAF 2016 00273.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the resultant loss of RPV level control represented a significant loss of operational control that could have affected the operability of the HPCI and reactor core isolation cooling (RCIC) systems, as well as the S/RVs, had their use again been required in the near term. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because operators did not stop when faced with uncertain conditions. Specifically, without otherwise having maintained status control on

the condensate transfer system cross-connect valve to the 'A' RHR loop, operators did not stop to positively establish the condition of the valve when it appeared in a conditional step in the procedure (that is, "if 10RHR-274 is open, then station an operator at 10RHR-274") (H.11).

Inspection Report# : [2016001](#) (*pdf*)

Significance:  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unintended Elevated Plant Risk During EDG Maintenance

The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.65, "Requirements for monitoring the effectiveness of maintenance at nuclear power plants," for failure to adequately manage the increase in risk during planned maintenance on the 'A' emergency diesel generator (EDG). Specifically, Entergy staff action to make the 'C' EDG unavailable while the 'A' EDG was already unavailable resulted in an unplanned increase in overall plant risk and deviation from the approved EDG outage risk management plan from a risk category of Green to the next higher risk category of Yellow. As immediate corrective action, the issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2015-05242.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the 'C' EDG was not available when it should have been, in accordance with the approved risk management plan, which resulted in an unplanned escalation of risk from Green to Yellow. Additionally, this finding was similar to example 7.e in IMC 0612, Appendix E, "Examples of Minor Issues." In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent actual loss of a safety function of a single train for greater than its Technical Specification (TS) allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Work Management, because FitzPatrick did not execute the 'A' EDG maintenance outage work activities as planned, and after deviating from that plan, did not identify and manage the risk of barring the 'C' EDG while the 'A' EDG was unavailable [H.5].

Inspection Report# : [2015004](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Post-Maintenance Testing of the Reactor Building Ventilation System Resulted in Short-Term Inoperability of Secondary Containment

The inspectors identified a self-revealing NCV of TS 5.4, "Procedures," for FitzPatrick staff's failure to perform adequate post-maintenance testing (PMT) following maintenance on a limit switch in the reactor building ventilation system in August 2014, that, along with another unrelated component failure in the reactor building ventilation system, resulted in secondary containment pressure, relative to the outside pressure, exceeding the TS limit of 0.25 inches of vacuum water gauge. As immediate corrective action, operators started both trains of the standby gas treatment system (SBGTS), which restored secondary containment pressure to within the TS limit. Operators

subsequently secured the 'A' refuel floor exhaust train and placed the 'B' train in service. The issue was entered into the CAP as CR-JAF-2015-04166.

The finding was more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, as a result of this event, secondary containment was not preserved, in that secondary containment pressure exceeded the limit of TS surveillance requirement (SR) 3.6.4.1.1. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a pressurized thermal shock issue, did not represent an actual open pathway in the physical integrity of the reactor containment, did not involve an actual reduction in function of hydrogen igniters in the reactor containment, and only represented a degradation of the radiological barrier function provided by the reactor building and SBGTS. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick staff did not ensure that procedures for PMT of the reactor building refuel floor exhaust damper limit switch following maintenance performed in August 2014, were adequate to support the nuclear safety function of the secondary containment (H.1).

Inspection Report# : [2016001](#) (*pdf*)

Significance: N/A Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of Inoperable Secondary Containment

The inspectors identified a SL IV NCV of 10 CFR 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the secondary containment system was not reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition That Could Have Prevented Fulfillment of a Safety Function." Specifically, following reasonable resolution of questions regarding the reliability of secondary containment differential pressure (d/p) instrumentation indications, FitzPatrick staff did not promptly report that, during a transfer from normal reactor building ventilation in service to the reactor building being isolated with the SBGTS in service, reactor building d/p briefly dropped below the TS required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. As immediate corrective action, the event was reported to the NRC in accordance with 10 CFR 50.72(b)(3)(v). The issue was entered into the CAP as CR-JAF-2015-05244 and CR JAF 2015-05265.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using Example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2016001](#) (*pdf*)

Significance: N/A Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of Inoperable Secondary Containment

The inspectors identified a Severity Level (SL) IV NCV of 10 CFR 50.72, "Immediate Notification Requirements for

Operating Nuclear Power Reactors,” because inoperability of the secondary containment system was not reported to the NRC within eight hours of when the need to do so should reasonably have been recognized, as required by 10 CFR 50.72(b)(3)(v), “Event or Condition that Could Have Prevented Fulfillment of a Safety Function.” Specifically, positive pressure in the secondary containment due to a previously unidentified equipment malfunction that occurred during transition between the reactor building being isolated and normal reactor building ventilation being in service was not promptly recognized as a condition that caused the single train secondary containment system to be inoperable and therefore to be reportable under 10 CFR 50.72. This issue was entered into the CAP as CR-JAF-2015-05244 and CR-JAF-2015-05265.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy’s ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC’s opportunity to review the matter. Using Example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was an SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, “Power Reactor Inspection Reports,” traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : [2015004](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Determine Dose Rates Prior to Entering a High Radiation Area (Section 2RS1)

The inspectors identified a self-revealing, Green NCV of technical specification (TS) 5.7.1, “High Radiation Area.” Specifically, on January 24 and 25, 2016, operations personnel failed to notify the Radiation Protection (RP) department and non-licensed operators in the field when operating plant equipment, which created high radiation areas (HRAs). These areas therefore were not surveyed by RP to determine dose rates prior to non-licensed operators entering the areas. Personnel entry into HRAs without knowledge of the current dose rates is a performance deficiency. In both instances, RP evaluated the operators’ dose, validated the dosimeter alarms, surveyed both areas in response to the dose rate alarms, and reposted the areas as HRAs. Entergy documented the events in condition reports (CR)-JAF-2016-00269 and CR-JAF-2016-00369

The finding was more than minor because it resulted in the unintended exposure of two workers and affected the Occupational Radiation Safety cornerstone attribute of program and process associated with exposure/contamination controls and if left uncorrected could result in more significant exposures. The finding was determined to be of very low safety significance (Green) because it was not related to as low as is reasonably achievable (ALARA), did not result in an overexposure or a substantial potential for overexposure, and did not compromise the licensee’s ability to assess dose. A cross-cutting aspect of Human Performance, Teamwork, was associated with this finding. Specifically,

licensed operators did not communicate to RP or non-licensed operators in the field when operating plant equipment which caused plant radiological conditions to change.

Inspection Report# : [2016002](#) (*pdf*)

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Conduct Operations to Minimize the Introduction of Residual Radioactivity to the Site (Section 2RS8)

The NRC identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 20.1406(c) due to Entergy not conducting operations to minimize the introduction of residual radioactivity into the site. For at least the past four years, Entergy allowed leakage of the solid radwaste processing system to occur resulting in spilled radioactive waste which accumulated and remained on the floor of the filter sludge tank room in the radwaste building. The failure to remove the accumulated solid radioactive waste is a performance deficiency. Entergy entered this issue into their corrective action program (CAP) as CR-JAF-2016-01784 with actions to characterize the extent of residual radioactivity and evaluate cleanup actions.

This issue is more than minor because it is associated with the program and process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure the licensee's ability to prevent inadvertent release and/or loss of control of licensed material. The finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Resolution, in that the condition was known to exist for over four years, impacted the radwaste system effectiveness to process solid radwaste, and had not been corrected.

Inspection Report# : [2016002](#) (*pdf*)

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : December 08, 2016

FitzPatrick

4Q/2016 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2016

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Preventive Maintenance Results In Transformer Failure and Reactor Scram

A self-revealing Green finding (FIN) was identified for Entergy staff's failure to properly implement the requirements of EN-DC-324, "Preventive Maintenance Program," Revision 16, to ensure proper preventive maintenance (PM) was implemented for non-safety-related 4KV transformer 71T-5. Specifically, Action Request (AR) 127566, PM change request to perform inspection, cleaning, and electrical testing of 4KV transformer 71T-5 was retired without a review by engineering as required by the PM program. As a result, transformer 71T-5 remained in service beyond its effective life without proper condition monitoring and maintenance, leading to its failure and a reactor scram on June 24, 2016. Entergy staff developed corrective actions to address the failure which included replacement of the transformer and re-establishing the condition monitoring and PM task. Entergy also performed an extent of condition review that confirmed the PM to clean, inspect, and test similar non-safety-related dry-type transformers was still active and performed within its required frequency.

This finding is more than minor because it is associated with the Equipment Performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Specifically, Entergy staff failed to ensure an adequate PM was in place for transformer 71T-5. The PM to ensure adequate cleaning and testing was cancelled in 2011, and transformer 71T-5 ultimately failed on June 24, 2016, resulting in a manual reactor scram. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because although the performance deficiency caused a reactor scram, it did not result in the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The inspectors did not assign a cross-cutting aspect to this finding because it is not indicative of current licensee performance. Specifically, the performance deficiency was determined to have occurred in 2011, the guidance in EN-DC-324 is clear regarding the PM change process, and no additional failures to follow the process have resulted in significant reactor transients.

Inspection Report# : [2016003](#) (*pdf*)

Mitigating Systems

Significance: G Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unintended HPCI Pump Suction Transfer during Pressure Control Mode Operation

The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for failure to maintain a condition specified in an emergency operating procedure. Specifically, while operating the high pressure coolant injection (HPCI) system in the pressure control mode, operators failed to override automatic transfer of the HPCI pump suction from the condensate storage tank (CST) to the suppression pool prior to the transfer actually occurring. As a result, operators had to revert to using the safety/relief valves (S/RVs) for pressure control, which introduced additional, unnecessary plant challenges. As immediate corrective action, operators secured HPCI, overrode the automatic HPCI pump suction transfer, realigned the pump suction to the CST, and restarted HPCI in the pressure control mode. The issue was entered into the corrective action program (CAP) as condition report (CR)-JAF-2016-00765.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the operators' failure to timely override automatic transfer of the HPCI suction to the suppression pool resulted in an additional, avoidable post-scrum pressure and level transient being placed on the reactor pressure vessel (RPV) and unnecessarily reduced the thermal capacity of the suppression pool. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of a safety function of a single train for greater than its technical specification (TS) allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because operators did not follow guidance of EOP-2 for the HPCI pump suction to be aligned to the CST by bypassing the HPCI pump suction swap to the suppression pool in a timely manner, such that the swap actually occurred (H.8).

Inspection Report# : [2016001](#) (*pdf*)

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Uncontrolled RPV Level Increase after Initiation of RHR Shutdown Cooling

The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for failure to take actions specified in the procedure for initiation of shutdown cooling. Specifically, prior to placing the 'A' loop of the residual heat removal (RHR) system into shutdown cooling, an operator was not stationed to close the condensate transfer system cross-connect valve to the 'A' RHR loop (10RHR 274), nor was the valve immediately closed after initiation of shutdown cooling, as specified by the operating procedure. This resulted in a significant loss of operational control, in that RPV level increased to the point of putting water down the main steam lines. As immediate corrective action, operators closed 10RHR-274, thus stopping the RPV inventory increase. The issue was entered into the CAP as CR JAF 2016 00273.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the resultant loss of RPV level control represented a significant loss of operational control that could have affected the operability of the HPCI and reactor core isolation cooling (RCIC) systems, as well as the S/RVs, had their use again been required in the near term. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding had a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because operators

did not stop when faced with uncertain conditions. Specifically, without otherwise having maintained status control on the condensate transfer system cross-connect valve to the 'A' RHR loop, operators did not stop to positively establish the condition of the valve when it appeared in a conditional step in the procedure (that is, "if 10RHR-274 is open, then station an operator at 10RHR-274") (H.11).

Inspection Report# : [2016001](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Post-Maintenance Testing of the Reactor Building Ventilation System Resulted in Short-Term Inoperability of Secondary Containment

The inspectors identified a self-revealing NCV of TS 5.4, "Procedures," for FitzPatrick staff's failure to perform adequate post-maintenance testing (PMT) following maintenance on a limit switch in the reactor building ventilation system in August 2014, that, along with another unrelated component failure in the reactor building ventilation system, resulted in secondary containment pressure, relative to the outside pressure, exceeding the TS limit of 0.25 inches of vacuum water gauge. As immediate corrective action, operators started both trains of the standby gas treatment system (SBGTS), which restored secondary containment pressure to within the TS limit. Operators subsequently secured the 'A' refuel floor exhaust train and placed the 'B' train in service. The issue was entered into the CAP as CR-JAF-2015-04166.

The finding was more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, as a result of this event, secondary containment was not preserved, in that secondary containment pressure exceeded the limit of TS surveillance requirement (SR) 3.6.4.1.1. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding was of very low safety significance (Green) because the performance deficiency was not a pressurized thermal shock issue, did not represent an actual open pathway in the physical integrity of the reactor containment, did not involve an actual reduction in function of hydrogen igniters in the reactor containment, and only represented a degradation of the radiological barrier function provided by the reactor building and SBGTS. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because FitzPatrick staff did not ensure that procedures for PMT of the reactor building refuel floor exhaust damper limit switch following maintenance performed in August 2014, were adequate to support the nuclear safety function of the secondary containment (H.1).

Inspection Report# : [2016001](#) (*pdf*)

Significance: N/A Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely 10 CFR 50.72 Notification of Inoperable Secondary Containment

The inspectors identified a SL IV NCV of 10 CFR 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the secondary containment system was not reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition That Could Have Prevented Fulfillment of a Safety Function." Specifically, following reasonable resolution of questions regarding the reliability of secondary containment differential pressure (d/p) instrumentation indications, FitzPatrick

staff did not promptly report that, during a transfer from normal reactor building ventilation in service to the reactor building being isolated with the SBGTS in service, reactor building d/p briefly dropped below the TS required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. As immediate corrective action, the event was reported to the NRC in accordance with 10 CFR 50.72(b)(3)(v). The issue was entered into the CAP as CR-JAF-2015-05244 and CR JAF 2015-05265.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using Example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects. Inspection Report# : [2016001](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Determine Dose Rates Prior to Entering a High Radiation Area (Section 2RS1)

The inspectors identified a self-revealing, Green NCV of technical specification (TS) 5.7.1, "High Radiation Area." Specifically, on January 24 and 25, 2016, operations personnel failed to notify the Radiation Protection (RP) department and non-licensed operators in the field when operating plant equipment, which created high radiation areas (HRAs). These areas therefore were not surveyed by RP to determine dose rates prior to non-licensed operators entering the areas. Personnel entry into HRAs without knowledge of the current dose rates is a performance deficiency. In both instances, RP evaluated the operators' dose, validated the dosimeter alarms, surveyed both areas in response to the dose rate alarms, and reposted the areas as HRAs. Entergy documented the events in condition reports (CR)-JAF-2016-00269 and CR-JAF-2016-00369

The finding was more than minor because it resulted in the unintended exposure of two workers and affected the Occupational Radiation Safety cornerstone attribute of program and process associated with exposure/contamination controls and if left uncorrected could result in more significant exposures. The finding was determined to be of very low safety significance (Green) because it was not related to as low as is reasonably achievable (ALARA), did not result in an overexposure or a substantial potential for overexposure, and did not compromise the licensee's ability to assess dose. A cross-cutting aspect of Human Performance, Teamwork, was associated with this finding. Specifically, licensed operators did not communicate to RP or non-licensed operators in the field when operating plant equipment which caused plant radiological conditions to change.

Inspection Report# : [2016002](#) (*pdf*)

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Conduct Operations to Minimize the Introduction of Residual Radioactivity to the Site (Section 2RS8)

The NRC identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 20.1406(c) due to Entergy not conducting operations to minimize the introduction of residual radioactivity into the site. For at least the past four years, Entergy allowed leakage of the solid radwaste processing system to occur resulting in spilled radioactive waste which accumulated and remained on the floor of the filter sludge tank room in the radwaste building. The failure to remove the accumulated solid radioactive waste is a performance deficiency. Entergy entered this issue into their corrective action program (CAP) as CR-JAF-2016-01784 with actions to characterize the extent of residual radioactivity and evaluate cleanup actions.

This issue is more than minor because it is associated with the program and process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure the licensee's ability to prevent inadvertent release and/or loss of control of licensed material. The finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Resolution, in that the condition was known to exist for over four years, impacted the radwaste system effectiveness to process solid radwaste, and had not been corrected.

Inspection Report# : [2016002](#) (*pdf*)

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : [2011009](#) (*pdf*)

Last modified : February 01, 2017



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Initiating Events

Significance: G Sep 30, 2016

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Preventive Maintenance Results In Transformer Failure and Reactor Scram

A self-revealing Green finding (FIN) was identified for Entergy staff's failure to properly implement the requirements of EN-DC-324, "Preventive Maintenance Program," Revision 16, to ensure proper preventive maintenance (PM) was implemented for non-safety-related 4KV transformer 71T-5. Specifically, Action Request (AR) 127566, PM change request to perform inspection, cleaning, and electrical testing of 4KV transformer 71T-5 was retired without a review by engineering as required by the PM program. As a result, transformer 71T-5 remained in service beyond its effective life without proper condition monitoring and maintenance, leading to its failure and a reactor scram on June 24, 2016. Entergy staff developed corrective actions to address the failure which included replacement of the transformer and re-establishing the condition monitoring and PM task. Entergy also performed an extent of condition review that confirmed the PM to clean, inspect, and test similar non-safety-related dry-type transformers was still active and performed within its required frequency.

This finding is more than minor because it is associated with the Equipment Performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Specifically, Entergy staff failed to ensure an adequate PM was in place for transformer 71T-5. The PM to ensure adequate cleaning and testing was cancelled in 2011, and transformer 71T-5 ultimately failed on June 24, 2016, resulting in a manual reactor scram. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because although the performance deficiency caused a reactor scram, it did not result in the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The inspectors did not assign a cross-cutting aspect to this finding because it is not indicative of

current licensee performance. Specifically, the performance deficiency was determined to have occurred in 2011, the guidance in EN-DC-324 is clear regarding the PM change process, and no additional failures to follow the process have resulted in significant reactor transients.

Inspection Report# : 2016003 (*pdf*)

Mitigating Systems Barrier Integrity

Significance: 6 Dec 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Ensure Proper Configuration Control of a PCIV During Planned Maintenance

An NRC-identified Green NCV of TS 5.4, "Procedures" was identified because Entergy staff did not implement procedure AP-12.06, "Equipment Status Control," as required. Specifically, Entergy personnel did not recognize the impact of a change associated with the tagout of a Primary Containment Isolation Valve (PCIV) associated with the 'C' RHR system. This resulted in 10MOV-13C being electrically isolated in the open position without being recognized as a PCIV and without proper entry into TS 3.6.1.3. Entergy entered this issue into their corrective action program (CAP) as condition report (CR) CR-JAF-2016-4419, and conducted meetings with each operating crew to discuss the event and re-inforce standards for equipment status control and maintaining a questioning attitude. Training was also provided to operators to review the scenario and discuss requirements associated with PCIVs.

This finding is more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone, and it impacted the cornerstone objective of providing reasonable assurance that physical design barriers (containment) protect the public from radionuclide releases caused by accidents or events. Specifically, Entergy staff did not recognize the impact of a change associated with the tagout of a containment isolation valve. The change in the tagout resulted in a failure to isolate the containment isolation valve and enter TS 3.6.3.1 prior to maintenance. The finding was similar to example 3.j, in Appendix E of IMC 0612, "Examples of Minor Issues," as given the PCIV was in an open position with power removed, a reasonable doubt of operability existed due to the valve's inability to perform its containment isolation function. The inspectors evaluated this finding using IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012 and Appendix H of IMC 0609, "Containment Integrity Significance Determination Process," issued May 6, 2004. The inspectors determined this finding was of very low safety significance (Green) because failure of the isolation valve which was critical to suppression pool integrity/scrubbing was less than 3 days. This finding has a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because Entergy failed to maintain a questioning attitude to identify an improper configuration associated with a PCIV tagout during planning and preparing for maintenance. Specifically, a tagout writer modified the configuration for a containment isolation valve, which was then not challenged or questioned during subsequent reviews. This resulted in the containment isolation valve being tagged out in the open position, a condition that rendered the valve inoperable.

Inspection Report# : 2016004 (*pdf*)

Emergency Preparedness Occupational Radiation Safety Public Radiation Safety Security

The security cornerstone is an important component of the ROP, which includes various security inspection activities the NRC uses to verify licensee compliance with Commission regulations and thus ensure public health and safety. The Commission determined in the staff requirements memorandum (SRM) for SECY-04-0191, "Withholding Sensitive Unclassified Information Concerning Nuclear Power Reactors from Public Disclosure," dated November 9, 2004, that specific information related to findings and performance indicators associated with the security cornerstone will not be publicly available to ensure that security-related information is not provided to a possible adversary. Security inspection report cover letters will be available on the NRC Web site; however, security-related information on the details of inspection finding(s) will not be displayed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : 2011009 (*pdf*)

Current data as of : August 03, 2017

Page Last Reviewed/Updated Wednesday, August 10, 2016



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Initiating Events

Significance: G Sep 30, 2016

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Preventive Maintenance Results In Transformer Failure and Reactor Scram

A self-revealing Green finding (FIN) was identified for Entergy staff's failure to properly implement the requirements of EN-DC-324, "Preventive Maintenance Program," Revision 16, to ensure proper preventive maintenance (PM) was implemented for non-safety-related 4KV transformer 71T-5. Specifically, Action Request (AR) 127566, PM change request to perform inspection, cleaning, and electrical testing of 4KV transformer 71T-5 was retired without a review by engineering as required by the PM program. As a result, transformer 71T-5 remained in service beyond its effective life without proper condition monitoring and maintenance, leading to its failure and a reactor scram on June 24, 2016. Entergy staff developed corrective actions to address the failure which included replacement of the transformer and re-establishing the condition monitoring and PM task. Entergy also performed an extent of condition review that confirmed the PM to clean, inspect, and test similar non-safety-related dry-type transformers was still active and performed within its required frequency.

This finding is more than minor because it is associated with the Equipment Performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Specifically, Entergy staff failed to ensure an adequate PM was in place for transformer 71T-5. The PM to ensure adequate cleaning and testing was cancelled in 2011, and transformer 71T-5 ultimately failed on June 24, 2016, resulting in a manual reactor scram. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because although the performance deficiency caused a reactor scram, it did not result in the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The inspectors did not assign a cross-cutting aspect to this finding because it is not indicative of

current licensee performance. Specifically, the performance deficiency was determined to have occurred in 2011, the guidance in EN-DC-324 is clear regarding the PM change process, and no additional failures to follow the process have resulted in significant reactor transients.

Inspection Report# : 2016003 (*pdf*)

Mitigating Systems

Barrier Integrity

Significance:  Jun 30, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Control Room Emergency Ventilation Air Supply (CREVAS) System

A self-revealing Green NCV of Technical Specification (TS) 3.7.3, "Control Room Emergency Ventilation Air Supply (CREVAS) System," and TS 3.7.4, "Control Room Air Conditioning (AC) System," was identified for the failure to declare one subsystem of the control room AC and CREVAS systems inoperable. Specifically, on August 16, 2016, control room operators failed to declare the 'A' CREVAS and 'A' control room AC subsystems inoperable due to a degraded damper actuator. As a result, the 'A' CREVAS and 'A' control room AC subsystems were inoperable from August 16, 2016, until a compensatory measure to assist the damper linkage by hand as needed was implemented on September 19, 2016, which exceeded the TS allowed outage time. On October 4, 2016, FitzPatrick personnel replaced the actuator. This issue was entered into the corrective action program (CAP) as JAF-CR-2016-3593.

The performance deficiency is more than minor because it is associated with the structure, system, and component (SSC) and barrier performance attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, this resulted in the 'A' control room AC and 'A' CREVAS subsystems being inoperable from August 16, 2016, to September 19, 2016, and the exceedance of the allowable TS out-of-service times. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because the performance deficiency did not represent a degradation of the radiological barrier function provided for the control room, and the finding did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere (i.e. the 'B' train of both subsystems remained operable). This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Evaluation, because FitzPatrick personnel failed to thoroughly evaluate the problem such that resolution addressed the cause. Specifically, FitzPatrick failed to fully evaluate the degraded condition during troubleshooting following the failed post-maintenance test (PMT) on August 16, 2016. Thorough testing and evaluation of the degraded actuator would have led to the identification of the need for replacement to restore the damper and its actuator to fully operable status.

Inspection Report# : 2017002 (*pdf*)

Significance:  Dec 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Ensure Proper Configuration Control of a PCIV During Planned Maintenance

An NRC-identified Green NCV of TS 5.4, "Procedures" was identified because Entergy staff did not implement procedure AP-12.06, "Equipment Status Control," as required. Specifically, Entergy personnel did not recognize the impact of a change associated with the tagout of a Primary Containment Isolation Valve (PCIV) associated with the 'C'

RHR system. This resulted in 10MOV-13C being electrically isolated in the open position without being recognized as a PCIV and without proper entry into TS 3.6.1.3. Entergy entered this issue into their corrective action program (CAP) as condition report (CR) CR-JAF-2016-4419, and conducted meetings with each operating crew to discuss the event and re-inforce standards for equipment status control and maintaining a questioning attitude. Training was also provided to operators to review the scenario and discuss requirements associated with PCIVs.

This finding is more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone, and it impacted the cornerstone objective of providing reasonable assurance that physical design barriers (containment) protect the public from radionuclide releases caused by accidents or events. Specifically, Entergy staff did not recognize the impact of a change associated with the tagout of a containment isolation valve. The change in the tagout resulted in a failure to isolate the containment isolation valve and enter TS 3.6.3.1 prior to maintenance. The finding was similar to example 3.j, in Appendix E of IMC 0612, "Examples of Minor Issues," as given the PCIV was in an open position with power removed, a reasonable doubt of operability existed due to the valve's inability to perform its containment isolation function. The inspectors evaluated this finding using IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012 and Appendix H of IMC 0609, "Containment Integrity Significance Determination Process," issued May 6, 2004. The inspectors determined this finding was of very low safety significance (Green) because failure of the isolation valve which was critical to suppression pool integrity/scrubbing was less than 3 days. This finding has a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because Entergy failed to maintain a questioning attitude to identify an improper configuration associated with a PCIV tagout during planning and preparing for maintenance. Specifically, a tagout writer modified the configuration for a containment isolation valve, which was then not challenged or questioned during subsequent reviews. This resulted in the containment isolation valve being tagged out in the open position, a condition that rendered the valve inoperable.

Inspection Report# : 2016004 (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

The security cornerstone is an important component of the ROP, which includes various security inspection activities the NRC uses to verify licensee compliance with Commission regulations and thus ensure public health and safety. The Commission determined in the staff requirements memorandum (SRM) for SECY-04-0191, "Withholding Sensitive Unclassified Information Concerning Nuclear Power Reactors from Public Disclosure," dated November 9, 2004, that specific information related to findings and performance indicators associated with the security cornerstone will not be publicly available to ensure that security-related information is not provided to a possible adversary. Security inspection report cover letters will be available on the NRC Web site; however, security-related information on the details of inspection finding(s) will not be displayed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual

respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : 2011009 (*pdf*)

Current data as of : September 05, 2017

Page Last Reviewed/Updated Wednesday, June 07, 2017



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Initiating Events

Mitigating Systems

Barrier Integrity

Significance: G Aug 07, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Control Room Emergency Ventilation Air Supply (CREVAS) System

Inspection Report# : 2017002 ([pdf](#))

Significance: G Dec 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Ensure Proper Configuration Control of a PCIV During Planned Maintenance

An NRC-identified Green NCV of TS 5.4, "Procedures" was identified because Entergy staff did not implement procedure AP-12.06, "Equipment Status Control," as required. Specifically, Entergy personnel did not recognize the impact of a change associated with the tagout of a Primary Containment Isolation Valve (PCIV) associated with the 'C' RHR system. This resulted in 10MOV-13C being electrically isolated in the open position without being recognized as a PCIV and without proper entry into TS 3.6.1.3. Entergy entered this issue into their corrective action program (CAP) as condition report (CR) CR-JAF-2016-4419, and conducted meetings with each operating crew to discuss the event and re-inforce standards for equipment status control and maintaining a questioning attitude. Training was also provided to operators to review the scenario and discuss requirements associated with PCIVs.

This finding is more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone, and it impacted the cornerstone objective of providing reasonable assurance that physical design

barriers (containment) protect the public from radionuclide releases caused by accidents or events. Specifically, Entergy staff did not recognize the impact of a change associated with the tagout of a containment isolation valve. The change in the tagout resulted in a failure to isolate the containment isolation valve and enter TS 3.6.3.1 prior to maintenance. The finding was similar to example 3.j, in Appendix E of IMC 0612, "Examples of Minor Issues," as given the PCIV was in an open position with power removed, a reasonable doubt of operability existed due to the valve's inability to perform its containment isolation function. The inspectors evaluated this finding using IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012 and Appendix H of IMC 0609, "Containment Integrity Significance Determination Process," issued May 6, 2004. The inspectors determined this finding was of very low safety significance (Green) because failure of the isolation valve which was critical to suppression pool integrity/scrubbing was less than 3 days. This finding has a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because Entergy failed to maintain a questioning attitude to identify an improper configuration associated with a PCIV tagout during planning and preparing for maintenance. Specifically, a tagout writer modified the configuration for a containment isolation valve, which was then not challenged or questioned during subsequent reviews. This resulted in the containment isolation valve being tagged out in the open position, a condition that rendered the valve inoperable.

Inspection Report# : 2016004 (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

The security cornerstone is an important component of the ROP, which includes various security inspection activities the NRC uses to verify licensee compliance with Commission regulations and thus ensure public health and safety. The Commission determined in the staff requirements memorandum (SRM) for SECY-04-0191, "Withholding Sensitive Unclassified Information Concerning Nuclear Power Reactors from Public Disclosure," dated November 9, 2004, that specific information related to findings and performance indicators associated with the security cornerstone will not be publicly available to ensure that security-related information is not provided to a possible adversary. Security inspection report cover letters will be available on the NRC Web site; however, security-related information on the details of inspection finding(s) will not be displayed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : 2011009 (*pdf*)

Current data as of : November 29, 2017

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Initiating Events

Mitigating Systems

Barrier Integrity

Significance: G Aug 07, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Control Room Emergency Ventilation Air Supply (CREVAS) System

A self-revealing Green NCV of Technical Specification (TS) 3.7.3, "Control Room Emergency Ventilation Air Supply (CREVAS) System," and TS 3.7.4, "Control Room Air Conditioning (AC) System," was identified for the failure to declare one subsystem of the control room AC and CREVAS systems inoperable. Specifically, on August 16, 2016, control room operators failed to declare the 'A' CREVAS and 'A' control room AC subsystems inoperable due to a degraded damper actuator. As a result, the 'A' CREVAS and 'A' control room AC subsystems were inoperable from August 16, 2016, until a compensatory measure to assist the damper linkage by hand as needed was implemented on September 19, 2016, which exceeded the TS allowed outage time. On October 4, 2016, FitzPatrick personnel replaced the actuator. This issue was entered into the corrective action program (CAP) as JAF-CR-2016-3593.

The performance deficiency is more than minor because it is associated with the structure, system, and component (SSC) and barrier performance attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, this resulted in the 'A' control room AC and 'A' CREVAS subsystems being inoperable from August 16, 2016, to September 19, 2016, and the exceedance of the allowable TS out-of-service times. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because the performance deficiency did not represent a degradation of the radiological barrier function provided for the control room, and the finding did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere (i.e. the 'B' train of both subsystems remained

operable). This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Evaluation, because FitzPatrick personnel failed to thoroughly evaluate the problem such that resolution addressed the cause. Specifically, FitzPatrick failed to fully evaluate the degraded condition during troubleshooting following the failed post-maintenance test (PMT) on August 16, 2016. Thorough testing and evaluation of the degraded actuator would have led to the identification of the need for replacement to restore the damper and its actuator to fully operable status.

Inspection Report# : 2017002 (*pdf*)

Emergency Preparedness Occupational Radiation Safety Public Radiation Safety Security

The security cornerstone is an important component of the ROP, which includes various security inspection activities the NRC uses to verify licensee compliance with Commission regulations and thus ensure public health and safety. The Commission determined in the staff requirements memorandum (SRM) for SECY-04-0191, "Withholding Sensitive Unclassified Information Concerning Nuclear Power Reactors from Public Disclosure," dated November 9, 2004, that specific information related to findings and performance indicators associated with the security cornerstone will not be publicly available to ensure that security-related information is not provided to a possible adversary. Security inspection report cover letters will be available on the NRC Web site; however, security-related information on the details of inspection finding(s) will not be displayed.

Miscellaneous

Significance: SL-III Dec 31, 2011

Identified By: NRC

Item Type: VIO Violation

EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations

During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : 2011009 (*pdf*)

Current data as of : February 01, 2018

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