

## FitzPatrick 2Q/2004 Plant Inspection Findings

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### 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\(pdf\)](#)

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### 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\(pdf\)](#)

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## **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\(pdf\)](#)

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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## **Public Radiation Safety**

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## **Physical Protection**

[Physical Protection](#) information not publicly available.

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## **Miscellaneous**

Last modified : September 08, 2004