

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\(pdf\)](#)

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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

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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