

# FitzPatrick

## 2Q/2007 Plant Inspection Findings

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### 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  $1 \times 10^{-6}$  (actual increase was in the high 10<sup>-8</sup> 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*)

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### 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*)

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## 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*)

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## 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*)

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## Occupational Radiation Safety

## Public Radiation Safety

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## 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.

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## 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*)

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