

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

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