



Home > Nuclear Reactors > Operating Reactors > Reactor Oversight Process > Plant Summaries > FitzPatrick > Quarterly Plant Inspection Findings

FitzPatrick – Quarterly Plant Inspection Findings

2Q/2017 – Plant Inspection Findings

On this page:

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness
- Occupational Radiation Safety
- Public Radiation Safety
- Security

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