FitzPatrick

Initiating Events

Significance: G May 20, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY IMPLEMENT THE MAINTENANCE RULE FOR THE OFFGAS RECOMBINER BYPASS VALVE SOV.
A solenoid-operated valve (SOV) had not been incorporated in the preventive maintenance program, which resulted in the degradation and failure of the solenoid valve seat. This SOV was located in the offgas recombiner system, and the SOV failure initiated the April 1, 2000 loss of a main condenser vacuum and subsequent reactor scram. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because the resulting reactor scram was within the analyzed transients of the licensing bases and the failure did not impact any mitigation system capabilities. The failure to include the offgas recombiner bypass valve SOV in the preventive maintenance program or otherwise evaluate the bases for not being included in the preventive maintenance program was a non-cited violation of NRC requirements. (Section 1R12)
Inspection Report# : 2000003*(pdf)*

Significance: G May 20, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
OPERATORS FAILED TO FOLLOW PLANT PROCEDURES BY NOT SCRAMMING THE REACTOR ON A LOSS OF CONDENSER VACUUM.
During the April 1, 2000 loss of main condenser vacuum, when operators decided to manually scram the reactor, they chose to trip the main turbine first, despite the absence of procedural steps to do this in the plant operating procedures. This finding was evaluated using the SDP and determined to be Green (of very low safety significance), because a turbine trip/reactor scram from 25% power is within the analyzed transients of the licensing basis and the action did not impact any mitigation system capabilities. The failure to follow plant operating procedures was a non-cited violation of NRC requirements. (Section 1R14)
Inspection Report# : 2000003*(pdf)*

Significance: G Nov 27, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ANALYZE OPERATION IN SINGLE ELEMENT CONTROL.
The reactor water level control system has been operated in single element control mode, vice three element control mode as specificed in the final safety analysis report, since approximately 1984. An evaluation as required by 10 CFR 50.59, Changes, Tests, and Experiments, was not performed for this change in the operation of the facility. The failure to perform the evaluation was determined to have very low risk significance because the reactor level control system is a reactor trip transient initiator that does not impact barrier or mitigation equipment. The failure to perform a safety evaluation is a violation of NRC requirements. This issue was determined to be a non cited violation. (Section 1R04)
Inspection Report# : 1999009*(pdf)*

Mitigating Systems

Significance: G Mar 31, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
HIGH PRESSURE COOLANT INJECTION (HPCI) SYSTEM OPERABILITY.
The inspectors determined that the operability determination for the high pressure coolant injection (HPCI) water intrusion event lacked rigor and did not provide a technical basis for long term operability. A review of corrective action system items related to HPCI operability identified a trend in this area. For example, continued operation with a leaking steam admission valve, combined with a lack of system monitoring and compensatory actions, resulted in unnecessary operational challenges to HPCI. These ranged from HPCI unavailability for emergent maintenance to an actual safety system functional failure. The focus on individual equipment issues prevented corrective actions that were broad enough to maintain equipment operability, and the lack of rigor in developing compensatory actions demonstrated a lack of review and general management oversight.

Although events resulting in HPCI being declared inoperable were chronic in nature, the circumstances of the individual events limited the duration of the unavailability such that the overall risk as determined using the SDP was GREEN (of very low safety significance).
Inspection Report# : 2001003*(pdf)*

Significance: G Mar 31, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
OPERATORS RESTORED A SAFETY RELATED UNIT COOLER TO SERVICE WITHOUT AN ADEQUATE SYSTEM RETEST.
Operators compromised the operability of a train of crescent area cooling by not completing the required flow balance test following cleaning of one of the coolers. The system lineup resulted in a train of coolers being inoperable instead of only one cooler as recognized by operations. This issue was a potential safety concern because the failure to implement appropriate procedural limitations could result in operators allowing additional items to be made inoperable that could limit the ability of mitigating systems. Using the SDP, this issue was determined to be GREEN (of low safety significance) because the time the cooler train was in an untested configuration did not exceed the technical specification allowed out of service time.
Inspection Report# : 2001003*(pdf)*

Significance: N/A Mar 31, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
OPERATORS FAILED TO COMPLY WITH TS REQUIREMENTS BY EXCEEDING THE AMOUNT OF LOW PRESSURE ECCS REMOVED FROM SERVICE AT ONE TIME
Contrary to TS 3.0 E, on March 19, 2001 at 4:00 a.m., the LPCI inverter was declared inoperable and removed from service for planned maintenance and remained inoperable longer than expected due to voltage control problems identified during post maintenance testing. With LPCI B out-of-service, the injection valve for RHR train B would have remained closed during a LOOP/LOCA. With EDG B inoperable, RHR C (which is part of RHR train A) would not have started during a LOOP/LOCA. Therefore, TS 3.0 E limited plant operations to 24 hours with both LPCI B inverter and EDG B inoperable. However, FitzPatrick operators failed to recognize that they were in the 24-hour shutdown action statement required by TS 3.0 E until March 20 at 2:30 p.m., at which time they entered this LCO. The maintenance on LPCI inverter B was completed, the system was declared operable on March 21 at 12:54 a.m. and the 24 hour TS action statement was exited. Continued plant operations with components in both trains of the RHR system inoperable for greater than the time allowed by TS 3.0 E was treated as a non cited violation.
Inspection Report# : 2001003*(pdf)*

Significance: G Feb 17, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.
Entergy did not properly evaluate a potentially risk significant common mode failure of the residual heat removal service water (RHRSW) and emergency service water (ESW) systems. A weld repair associated with the hinge pin in an RHRSW check valve failed and prevented proper alignment of the valve disc on the seat. The weld repair had been performed on three other RHRSW check valves and two ESW check valves, but these valves were not evaluated. This failure to adequately implement the corrective action system for a potential common mode failure of two risk significant safety systems was evaluated using the SDP and determined to be Green (of very low safety significance) because after actual inspection of the similar valves, the systems remained operable.
Inspection Report# : 2000013*(pdf)*

Significance: G Feb 17, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM.
Following the evaluation of erroneous flow indications on the high pressure coolant injection system, Entergy did not adequately consider potential venting issues with other safety systems. The inspectors concluded that similar conditions to those noted on HPCI could have reasonably existed on the other safety systems. This failure to adequately implement the corrective action system for a potential issue that could reasonably impact multiple safety systems was evaluated using the SDP and determined to be Green (of very low safety significance), because after actual inspections and system venting checks, the other systems remained operable.
Inspection Report# : 2000013*(pdf)*

Significance: G Nov 18, 2000
Identified By: NRC
Item Type: FIN Finding

INADEQUATELY WRITTEN DEFICIENCY AND EVENT REPORT EVALUATING HIGH PRESSURE COOLANT INJECTION SYSTEM.
The inspector determined the deficiency and event report (DER) response written to evaluate deficiencies on the high pressure coolant injection (HPCI) system inadequate, because two of the deficiencies that could have had a significant impact on HPCI operability were not adequately addressed. Specifically, the failure of reversing chamber bolts on the interior of the turbine casing was mis-characterized as normal wear. Additionally, damage to the governor speed sensor was attributed to installation damage without an appropriate basis. The evaluations of these deficiencies were of concern because if not adquately corrected, the conditions could have resulted in HPCI inoperability. However, this inspection finding was considered to have very low safety significance, because after reevaluation the original conclusions were supported and the conditions did not impact HPCI operability. No violation of requiremetns was identified. (Section 1R15).
Inspection Report# : 2000009*(pdf)*

Significance: G Sep 30, 2000
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO COMPLETE TS-REQUIRED CALIBRATION OF IRMs AND APRMS PRIOR TO CHANGING OPERATING MODES.
During an unplanned reactor shutdown on August 27, 2000, NYPA was unable to complete the technical specification (TS) required calibration of certain intermediate range monitor (IRM) and average power range monitor (APRM) functions prior to changing plant operating modes. The cause of this event was poor preplanning for a rapid plant shutdown contingency. NYPA was unaware of an overly restrictive technical specification requirement that conflicted with a rapid plant shutdown. The failure to complete the calibration was evaluated using the SDP and determined to be Green (of very low safety significance) because it did not result in a loss of a safety function. NYPA requested and was granted enforcement discretion prior to completing the shutdown. The failure to complete the TS-required calibration of the IRMs and APRMs is a non-cited violation of NRC requirements. (Section 1R22)
Inspection Report# : 2000006*(pdf)*

Significance: G Sep 30, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO ENVIRONMENTALLY QUALIFY THE MINIMUM FLOW VALVE CONTROL CIRCUITS FOR THE CORE SPRAY AND HIGH PRESSURE COOLANT INJECTION SYSTEMS.
NYPA reported in Licensee Event Report 50-333/00-009 that portions of the control circuits for the high pressure coolant injection (HPCI) and core spray (CS) systems minimum flow valves were not environmentally qualified as specified in 10 CFR 50.49. This issue was evaluated using the SDP and determined to be Green (of very low safety significance) because the failures to the HPCI and CS systems due to the unqualified control circuits were only credible during certain high energy line break accident conditions, which have a low probability of occurring. The failure to environmentally qualify the HPCI and CS minimum flow valve control circuits is a non-cited violation of NRC requirements. (Section 4OA5.4)
Inspection Report# : 2000006*(pdf)*

Significance: G Aug 19, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ENTER HPCI DEFICIENCIES INTO THE DER SYSTEM AS REQUIRED BY SITE PROCEDURE.
During a review of high pressure coolant injection (HPCI) maintenance records, the inspectors identified two NYPA-identified issues that potentially impacted HPCI operability, but had not been entered as Deficiency and Event Reports (DERs). Specifically, the issues included Problem Identifications (PIDs) written to document high resistance across a set of contacts involved with the HPCI system minimum flow valve and a HPCI exhaust drain pot switch that did not function properly. Both of these issues should have been entered into the DER system but were not. Additionally, although each issue was evaluated for operability, the inspectors considered the evaluations and associated actions inadequate. These issues were evaluated using the SDP and determined to be Green (very low safety significance) because subsequent evaluation concluded that HPCI remained operable. The failure to enter these deficiencies into the DER system in accordance with NYPA procedures is a non-cited violation of NRC requirements. (Section 1R04)
Inspection Report# : 2000005*(pdf)*

Significance: G Aug 19, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE IMMEDIATE CORRECTIVE ACTIONS TAKEN FOR PREVIOUS IDENTIFIED POST MAINTENANCE TEST DEFICIENCIES.
Ineffective corrective actions resulted on NCV 0500333/2000-004-003 associated with inadequate post maintenance test instructions, as evidenced by similar issues being subsequently identified with control room air-conditioning system post maintenance testing. This failure to implement appropriate corrective actions was evaluated using the SDP and determined to be Green (of very low safety significance) because no examples were identified that resulted in safety system inoperability. The failure to take adequate corrective actions was a non-cited violation of NRC

requirements. (Section 1R19)
Inspection Report# : 2000005*(pdf)*

Significance: G Jul 18, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
OPERABILITY DETERMINATION ON RCIC WAS NOT COMPLETED IN A TIMELY MANNER.
The operability determination performed to address an issue with the installation of the reactor core isolation cooling (RCIC) steam leakage detection system was not completed in a timely manner and lacked technical detail. This finding was determined to be Green (of very low safety significance) using the SDP because the steam leak detection system remained operable. The failure to complete the operability determination as required by station procedures was a non-cited violation of NRC requirements. (Section 1R15)
Inspection Report# : 2000004*(pdf)*

Significance: G Jul 18, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
MODIFICATION TO THE RHRSW STRAINER WAS PERFORMED WITHOUT PROPER ENGINEERING REVIEW.
The inspectors identified that NYPA had not performed an engineering analysis for the use of Belzona Metals on the seating surface of the residual heat removal service water (RHRSW) strainer isolation valves. The addition of Belzona Metals was considered a modification and as such required appropriate review and documentation. This issue screened out of the SDP as Green (of very low safety significance) because the evaluation of the Belzona Metals application was later completed prior to returning the RHRSW system to operable status and the application was ultimately found acceptable. The failure to evaluate the use of Belzona Metals prior to installation was a non-cited violation of NRC requirements. (Section 1R17)
Inspection Report# : 2000004*(pdf)*

Significance: G Jul 18, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
RETEST DOCUMENTS FOR THE RHRSW STRAINER WORK WERE INADEQUATE.
The retest documents associated with the RHRSW system varied significantly in quality and adequacy. Some of the tests were inadequate to test the functions of the components which were repaired and thus were considered violations of NRC requirements. The specific examples were evaluated using the SDP and collectively determined to be Green (of very low safety significance) because the identified examples were not considered likely to result in safety system inoperability. (Section 1R19)
Inspection Report# : 2000004*(pdf)*

Significance: G May 20, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IMPLEMENT THE CORRECTIVE ACTION PROGRAM.
Upon determining that the voltage to the reactor core isolation cooling (RCIC) system components was less than the minimum required, NYPA failed to initiate a deficiency and event report or evaluate the impact of condition on system operability. This finding was evaluated using the SDP and determined to be Green (of very low safety significance) because the RCIC system remained operable. However, the failure to enter this item into the corrective action system and assess equipment operability was a non-cited violation of NRC requiremetns. (Section 1R15)
Inspection Report# : 2000003*(pdf)*

Significance: G May 05, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
NYPA FAILED TO CORRECT PROBLEMS WITH RCIC AND RESTORE OPERABILITY PRIOR TO CHANGING MODES DURING REACTOR STARTUP ON OCTOBER 26, 1999
NYPA's extent of condition review associated with inadequate HPCI problem identification during post trip reviews was inadequate. The NRC identified that during the October 14, 1999, reactor scram and subsequent HPCI overspeed event, RCIC had not functioned as designed. The RCIC system injected at a nominal 355 gpm versus the design flowrate of 400 gpm within 30 seconds of the initiation signal. The inspector determined that there were several missed opportunities to identify the degraded system performance. The failure to identify this condition, declare RCIC inoperable, and take appropriate corrective actions to restore operability, resulted in a Non-Cited violation of Technical Specification 3.5.E.2 requirements. Specifically, the RCIC system had been inoperable for a time period exceeding the the allowable out of service time in the TSs. The

NRC determined this to be a Green finding (i.e., an issue of very low safety significance) based on NYPA's analysis which concluded that RCIC would have been able to perform its safety function at the lower flowrates achieved.
Inspection Report# : 2000008*(pdf)*

Significance: G Apr 13, 2000
Identified By: NRC
Item Type: FIN Finding
FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING OPERABILITY OF A CRESENT AREA COOLER
The team determined through an independent calculation that the licensee had not identified and followed Administrative Procedure requirements to declare the "F" Crescent Area cooler inoperable due to its effectiveness being below the acceptance crieria for an operable unit cooler. The issue was considered to have low risk significance because four out of five coolers remained operable and therefore operability of the associated emergency core cooling system (ECCS) components was not challenged. The failure to declare the cooler inoperable in accordance with administrative procedure AP 01.04 requirements was the second example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01).
Inspection Report# : 2000007*(pdf)*

Significance: G Apr 13, 2000
Identified By: NRC
Item Type: FIN Finding
FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS GOVERNING THERMAL PERFORMANCE TESTING FOR A UNIT COOLER
When as-found flowrates were less than the required minimum design flowrates for the 67UC-16A unit cooler, the procedure required a thermal performance test or an engineering evaluation to be performed for the time period since the last test performance. When as-left flowrates are below minimum design, a thermal performance test and an engineering evaluation were required. There was no indication that these procedural requirements were satisfied during a review of the September 1999 test results. The failure to follow requirements within the quarterly ESW flow test was the third example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." (See NCV 2000007-01)
Inspection Report# : 2000007*(pdf)*

Significance: G Apr 13, 2000
Identified By: NRC
Item Type: FIN Finding
FAILURE TO PROPERLY IMPLEMENT CORRECTIVE ACTION PROGRAM REGARDING MAINTENANCE SOFTWARE REQUESTS.
A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to properly process conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, DER-99-02858 was closed based on the initiation of Maintenance Software Request (MSR) 492 on December 15, 1999. MSRs are an informal mechanism used in the White Plains Corporate Office for tracking database change requests and problems. MSRs are not acted on in accordance with, nor considered as part of, the corrective action program. Therefore, MSRs are not a valid method for tracking/prioritizing corrective actions, nor for closing DERs. This was the second example of a Non-Cited Violation in the area of the corrective action program. (See NCV 2000007-02)
Inspection Report# : 2000007*(pdf)*

Significance: G Apr 13, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IMPLEMENT PROCEDURAL REQUIREMENTS OF THE SW INSPECTION PROGRAM.
On February 12, 2000, the licensee determined that documentation was not readily available to demonstrate that the procedural requirements of the Service Water inspection program were being followed. The team noted that there were no inspection sheets available which recorded and evaluated the diesel generator jacket water cooler heat exchanger "as found" condition. These components are not thermal performance tested and calculations of record assume that the design fouling factors are maintained by cleaning. This issue was determined to have low risk significance with regard to the diesel generator jacket water coolers based on existing ESW flow margin and lake temperature. Nonetheless, the failure to implement procedure requirements was the first example of a Non-Cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."
Inspection Report# : 2000007*(pdf)*

Significance: G Apr 13, 2000
Identified By: NRC

Item Type: NCV NonCited Violation
FAILURE TO PROPERLY IMPLEMENT THE CORRECTIVE ACTION PROGRAM FOR DEGRADED FLOW TO THE WEST ELECTRIC BAY COOLER
A Non-Cited Violation (NCV) was identified regarding ineffective corrective action associated with the licensee's failure to promptly identify conditions adverse to quality and to take timely corrective actions to address such conditions. Specifically, the licensee's evaluation for a degraded flow condition to the west electric bay cooler, identified in September 1999 flow testing, was ineffective as the cooler check valve failed to open in the subsequent December 1999 test. This issue was determined to have low risk significance because the east electric bay cooler was operable at the time and only one electric bay cooler is required to receive ESW flow to mitigate a design basis accident. Nonetheless, the failure to identify and correct conditions adverse to quality is a violation of NRC requirements. This was the first example of a Non-Cited Violation in the area of the corrective action program.
Inspection Report# : 2000007*(pdf)*

Significance: G Apr 01, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE SURVEILLANCE TEST METHOD FOR ECCS KEEP FILL SYSTEMS
The surveillance testing on the keep fill parts of the core spray and the low pressure coolant injection system discharge piping was inadequate because the test method depended on the keep fill level switches (which had a history of being unreliable) to verify that the keep fill system was operating properly. The technical specification surveillance test requirements were not met for cases in which the level switches failed. However, based on other available indications, such as keep fill pumps operating, keep fill system pressure indication, and satisfactory CS and LPCI pump operation, the inspectors concluded that there was reasonable assurance that the systems would have performed their safety functions. The inadequate surveillance test was determined to be an NCV. The issue was determined to be GREEN (very low safety significance) using the SDP.
Inspection Report# : 2000002*(pdf)*

Significance: G Apr 01, 2000
Identified By: NRC
Item Type: FIN Finding
INCOMPLETE OPERABILITY EVALUATION OF THE 125 VDC ELECTRICAL SYSTEM
NYPA performed an incomplete evaluation of the safety significance of a ground indication on one of the two safety- related station battery busses. NYPA's evaluation focused on the apparent cause of the ground, but did not address the degraded but operable condition of this risk significant safety system. No violation of NRC requirements was identified. This issue was evaluated using the significance determination process (SDP) and determined to be GREEN (very low safety significance) because the battery system remained operable.
Inspection Report# : 2000002*(pdf)*

Significance: G Sep 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PERFORM EXTENT OF CONDITION REVIEW FOR DEFICIENT CROSS-TIE HOSES.
Entergy failed to perform an extent of condition review following the discovery of an emergency operating procedure contingency hose that was too short. Upon questioning by the inspectors, Entergy identified that the alternate boron injection hose was also too short. This issue was considered more than minor because the ability to use the alternate boron injection path is important for anticipated transient without scram mitigation. However, this was determined to be of very low significance (Green) because the hose was adequate to connect to one of the two control rod drive (CRD) pumps, and at least one train of the standby liquid control system was available for ATWS mitigation for the duration of this condition (i.e., inadequate contingency hose length). This failure to perform an adequate extent of condition review was considered a non-cited violation of NRC requirements. (Section 1R15)
Inspection Report# : 2001009*(pdf)*

Significance: G Sep 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE POST-MAINTENANCE TESTS.
The inspectors identified that the post maintenance test for the station service tap changer modification was inadequate in that it lacked clear test requirements and acceptance criteria. This issue was considered more than minor because unclear test requirements and criteria can mask equipment performance problems and have a credible impact on plant safety. In this case, the inspector intervened and the test criteria was corrected prior to performance of the test. Therefore, this issue screens out of the phase one SDP process as having very low safety significance (Green). This issue was considered a non-cited violation of NRC requirements. (Section 1R19)
Inspection Report# : 2001009*(pdf)*

Significance: G Sep 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO DETERMINE REFERENCE VALUES FOLLOWING PUMP REPLACEMENT.
The acceptance criteria contained in the quarterly inservice test procedure for the 'B' emergency service water pump was not updated following pump replacement. This issue was considered to be more than minor in that lack of acceptance criteria applicable to the new pump could mask degrading pump performance. However, this was determined to be of very low safety significance (Green) because the pump continued to operate acceptably. Failure to determine new acceptance criteria and incorporate them in the test procedure was a non-cited violation of NRC requirements. (Section 1R22)
Inspection Report# : 2001009*(pdf)*

Significance: G Sep 30, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
APRM/RBM TECHNICAL SPECIFICATIONS NOT FOLLOWED.
Licensee identified violation, issued as NCV 05000333/01-09-05, was identified during a review of licensee event report (LER) 2001-02.
Inspection Report# : 2001009*(pdf)*

Significance: G May 19, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO COMPLETE TIMELY CORRECTIVE ACTION REGARDING A DEGRADED CONDITION IDENTIFIED IN THE RHR HEAT EXCHANGERS.
The inspector determined that a significant corrective action specified for a degraded condition identified on the A residual heat removal (RHR) heat exchanger had not been completed. Specifically, upon discovery of a degraded condition on the A RHR Heat Exchanger in October 1998, Entergy did not examine the B RHR heat exchanger as planned in October 2000 or perform an appropriate engineering evaluation regarding the potential degraded condition. The ineffective corrective action was evaluated using the SDP and determined to be Green (of very low safety significance) because the subsequent engineering evaluation performed by Entergy determined that the expected condition on the B RHR heat exchanger would not impact the ability of the RHR system to perform its safety function. This finding was a non-cited violation of NRV requirements (Section 1 R07)
Inspection Report# : 2001004*(pdf)*

Significance: G Feb 19, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CORRECTIVE ACTIONS FOR A RHRSW STRAINER HAVING A HIGH DIFFERENTIAL PRESSURE INDICATION.
The inspectors identified untimely corrective actions for a strainer with a high differential pressure in the residual heat removal service water system. An inappropriate priority was assigned, which resulted in a delay for approximately three and one half months. This issue was considered to be Green (very low safety significance) using the significance determination process (SDP) phase 1 evaluation, because the system was still capable of performing the safety function using the second strainer. The failure to promptly correct this condition was determined to be a non-cited violation.
Inspection Report# : 2000001*(pdf)*

Significance: G Jan 08, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROMPTLY IDENTIFY & TIMELY CORRECT CONDITIONS ADVERSE TO QUALITY.
Two examples of an non-cited violation of corrective action (CA) requirements associated with NYPA's failure to promptly identify conditions adverse to quality and to take timely corrective actions. Specifically, (1) following the identification by the NRC that surveillance testing on HPCI was inadequate to monitor HPCI governor control system performance due to the failure to incorporate vendor recommendations, it took NYPA about one month to incorporate this condition adverse to quality into their CA program; and (2) the corrective actions for repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found acceptance criteria were not implemented for six weeks. These issues were determined to have very low risk significance because there was no impact on HPCI system operability.
Inspection Report# : 1999010*(pdf)*

Significance: W Nov 27, 1999
Identified By: NRC
Item Type: VIO Violation
HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.
As demonstrated during the post-scram HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)
Inspection Report# : 2000008*(pdf)*

Significance: G Nov 27, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE POST TEST MAINTENANCE TEST REQUIREMENTS.
The post maintenance test requirements for the high pressure coolant injection (HPCI) system troubleshooting and maintenance were inadequate. Following the completion of the post maintenance test (PMT) on October 26, 1999, operations declared HPCI operable. Approximately 20 hours later, system engineering completed an evaluation of additional system parameters, which were not requried by the PMT, and identified that problems with the control system existed. The licensee declared HPCI inoperable from the time of the PMT completion. Therefore, the inadequate PMT resulted in an approximately 20-hour delay in determining to have very low risk significance using the phase 1 SDP (Green) because HPCI inoperability remained within the technical specification allowable outage time. The failure to develop an adequate written test procedure is a violation of NRC requirements. This issue was determined to be a non cited violaiton. (Section 1R19)
Inspection Report# : 1999009*(pdf)*

Significance: W Nov 27, 1999
Identified By: NRC
Item Type: VIO Violation
HPCI SYSTEM DEGRADATION CAUSED BY INEFFECTIVE CORRECTIVE ACTIONS.
As demonstrated during the post-scram HPCI (high pressure coolant injection) system initiation on October 14, 1999, problems existed within the HPCI governor controls that degraded HPCI performance. An improper oil operating pressure resulted in abnormalities in HPCI governor control system performance, which adversely affected HPCI performance during this event and could have resulted in an overspeed trip during a system injection. This issue was determined to be White (low to moderate safety significance) because HPCI is an important mitigating system during a loss of offsite power event and was susceptible to an overspeed trip for a period of greater than 30 days. NYPA had missed several opportunities to properly set the system hydraulic oil operating pressure. In addition, HPCI system performance monitoring was ineffective as evidenced by the failure of NYPA to identify the problems with the electronic speed limiter, hydraulic oil pressure, spring tension and general degradation of the system and components. The inspectors concluded that this ineffective corrective action represented a violation. Also, based on new information reviewed, the inspectors concluded that the apparent violation issued in NRC Inspection Report 05000333/1999009 regarding inadequate test control of the high pressure coolant injection (HPCI) system was incorrect and thus was not issued. (Final Significance Determination)
Inspection Report# : 1999009*(pdf)*
Inspection Report# : 2000001*(pdf)*

Significance: G Nov 27, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURES TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.
Three examples were identified where NYPA failed to identify conditions adverse to quality. Specifically, (1) during the post transient evaluation of the August 3, 1998, plant scram, NYPA failed to identify that the HPCI system experienced an overpressure condition; (2) NYPA failed to identify repeated failures of the HPCI electronic speed limiter setpoint to meet the as-found calibration acceptance criteria; and (3) during their 10 CFR 50.54 Final Safety Analysis Report (FSAR) validation review, NYPA failed to identify that the FSAR description of the HPCI injection valve operations was incorrect. The failure to identify these issues was determined to have very low risk significance because there was no impact on HPCI system operability. Nonetheless, the failure to identify conditions adverse to quality is a violation of NRC requirements. These issues were three examples of a non cited violation. (Section 1R03.2)
Inspection Report# : 1999009*(pdf)*

Significance: G Oct 18, 1999
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO ADEQUATELY ESTABLISH THE CORE SPRAY TIMER CALIBRATION TOLERANCES.
NYPA reported in LER 50-333/99-007, that time delay for the automatic start function of both divisions of the core spray system exceed the values allowed by technical specifications. However, based on an evaluation of the as-found data, NYPA determined that the discrepancy would not have prevented the emergency diesel generators or the core spray system from completing the intended safety function. This issue had a very low risk significance since the discrepancy did not prevent the systems from performing the intended safety functions. This issue was determined to be a non-cited violation. (Section 4OA4.4)
Inspection Report# : 1999008*(pdf)*

Significance: G Oct 18, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PERFORM INDEPENDENT ENGINEERING VERIFICATION.
The inspectors observed engineers not complying with test procedure requirements. Specifically, the test data for a reactor water level response test was not being properly independently verified. Incorrect review of this test data could have allowed continued operation with inadequate feedwater system response, a transient initiator. Additionally, the inspector noted that two levels of plant management, specifically directed by plant administrative procedures to oversee the performance of the test, failed to notice or correct the issue until prompted. This procedural non-compliance was determined to have very low risk significance because it did not result in a direct impact to equipment performance and only had the potential to compromise the value of the independent verification effort in identifying a problem that was missed by the first reviewer. This issue was determined to be a non-cited violation. (Section 1R19)
Inspection Report# : 1999008*(pdf)*

Significance: G Oct 18, 1999
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO CONTROL THE FIRE PROTECTION SYSTEM CONFIGURATION.
Through a review of operational experience information, NYPA identified a long-standing degraded fire protection barrier in the cable spreading room. Specifically, the plug for the cable spreading room floor drain was discovered not installed. The drain plug was required by plant design and without it installed, the floor drain provided a vent path that would have degraded the effectiveness of the automatic carbon dioxide (CO_2) fire suppression system. This long-standing problem was determined to have had a very low risk significance after evaluating the alternative safe shutdown and additional fire fighting capabilities which existed, a conservative assumption for medium degradation of the automatic CO_2 suppression system, and the low likelihood of a fire in the cable spreading room. This issue was determined to be a non-cited violation. (1R05)
Inspection Report# : 1999008*(pdf)*

Significance: G Oct 18, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY INSTALL AN EMERGENCY SERVICE WATER VALVE FASTENERS.
The inspectors identified that the "B" emergency service water (ESW) supply isolation valve had questionable yoke mounting bolt thread engagement, and that no lock-washers were provided with these fasteners. The licensee determined that the condition was not in accordance with their installation requirements, declared the system inoperable, replaced the bolts and installed lock-washers. Subsequently, the licensee evaluated the as-found condition and determined that the valve would have been able to perform the intended safety function. The as-found condition had very low risk significance because, although the ESW system is the most risk-significant system at FitzPatrick according to the licensee's Individual Plant Examination, the valve was only considered degraded and it was still capable of performing the intended safety function. Thisissue was determined to be a non-cited violation. (Section 1R03)
Inspection Report# : 1999008*(pdf)*

Significance: G Aug 28, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ADEQUATELY ESTABLISH THE RHR LOW FLOW SWITCH SETPOINTS.
The inspectors identified that instrument uncertainties were not adequately incorporated into the residual heat removal system minimum flow valve setpoint analysis. Subsequently, the licensee identified additional discrepancies, which, in total, caused the setpoint to be inadequate to ensure

pump protection during low flow conditions. The inspectors also noted that ineffective communications between the engineering and operations departments resulted in the shift manager using incorrect information as part of the bases for initially justifying system operability. This issue was considered to have very low risk significance because the loss of RHR pump low flow protection was only credible during certain loss-of-coolant-accident conditions, which have a low probability of occurring.
Inspection Report# : 1999007*(pdf)*

Significance: G Jul 17, 1999
Identified By: NRC
Item Type: FIN Finding
EMERGENCY DIESEL GENERATOR EQUIPMENT FAILURES
The failure of the circulating lube oil pump for the "A" emergency diesel generator (EDG), and a subsequent relay failure during the post-maintenance test were evaluated for overall plant risk. These equipment failures, which resulted in emergency diesel generator inoperability, were determined to be green using the significance determination process. To determine the safety significance of this event, the inspectors considered unavailability, the other equipment unavailable during the period, and success paths for a loss-of offsite-power (LOOP) at the FitzPatrick Station as described in the licensee's Individual Plant Examination (IPE), and concluded that the increase in risk was very low.
Inspection Report# : 1999006*(pdf)*

Significance: G Jul 17, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO INITIATE A DEFICIENCY REPORT
Mechanics altered the design of a safety bus control power fuse block and did not document the non-conformance. The fuse block manufacturer required grease on the fuse block contacts to prevent a loss of function due to corrosion. This grease was omitted during the assembly process and the omission was not entered into the corrective action system for resolution. The failure to initiate a deficiency report was contrary to station procedures, which require a DER to be initiated for conditions adverse to quality, and was a violation of NRC requirements. The failure of this fuse clip could have resulted in a loss of one of the two plant safety electrical supply busses. The significance of this issue was considered very low because it did not have an immediate impact on equipment performance.
Inspection Report# : 1999006*(pdf)*

Significance: G Jul 17, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ADEQUATELY CONTROL THE CONFIGURATION OF THE HPCI SYSTEM
The inspectors identified approximately 25 minor discrepancies during a walkdown of the HPIC system. The large number of discrepancies co-existing on a single safety system represents a lapse in control of the system configuration and a violation of NRC requirements. Furthermore, the inspectors noted that it took the licensee an excessive amount of time, approximately two weeks, to enter most of the discrepancies into their corrective action program. However, because the discrepancies did not impact equipment operability the issue had a very low risk significance as determined by the significance determination process.
Inspection Report# : 1999006*(pdf)*

Barrier Integrity

Significance: G Aug 11, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PERFORM POST-MAINTENANCE TESTING.
A Non-Cited Violation of 10CFR50, Appendix, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phas I of the SDP.
Inspection Report# : 2000011*(pdf)*

Significance: G Jul 18, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
THE TORUS TO DRYWELL VACUUM BREAKER SURVEILLANCE TEST DID NOT CONTAIN ADEQUATE TEST ACCEPTANCE CRITERIA.
NYPA failed to provide an adequate acceptance criteria for the maximum acceptable torque needed to exercise the torus to drywell vacuum breakers in the associated quarterly surveillance test procedure. The SDP concluded that this finding was Green (of very low safety significance) because after determining the acceptance torque limits, all test results since the procedure was established were found to be satisfactory. Nonetheless, the failure to provide adequate acceptance criteria is a non-cited violation of NRC requirements. (Section 1R22)
Inspection Report# : 2000004*(pdf)*

Significance: G May 20, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CONTROL CONTRACTORS PERFORMING TESTING ON THE SGTS.
NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. The contractor did not perform the test with a NYPA controlled procedure. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the procedure used was adequate and the SGT system remained operable. However, the failure to adequately control procedures was a non-cited violation of NRC requirements. (Section 1R22)
Inspection Report# : 2000003*(pdf)*

Significance: G May 20, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE OF NYPA CONTRACTORS TO IMPLEMENT THE CORRECTIVE ACTION SYSTEM WHILE PERFORMING TESTING ON THE SBGT SYSTEM.
NYPA did not adequately control a contractor performing testing of the standby gas treatment (SGT) system. Specifically, deficiencies identified by the contractor were not entered into the NYPA corrective action program. In addition, NYPA personnel associated with this testing did not appear to be aware of these NYPA expectations. The SDP concluded that this finding was Green (very low safety significance) because the SGT system remained operable. However, the failure to document conditions adverse to quality was a non-cited violation of NRC requirements. (Section 1R22)
Inspection Report# : 2000003*(pdf)*

Significance: G Nov 18, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
SAFETY RELIEF VALVE SETPOINT DRIFT

Inspection Report# : 2001010*(pdf)*

Significance: G Jun 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CORRECTIVE ACTIONS TO PREVENT RECURRING LOCAL LEAK RATE TTESTING FAILURES OF MAIN STEAM ISOLATION VALVES
The inspectors determined that Entergy failed to take adequate corrective actions to prevent repeated local leak rate testing failures of select main steam isolation valves for three consecutive operating cycles. These failures resulted in a recurring containment leakage pathway through the D main steam line. The leakage path through the D main steam line was evaluated using the significance determination process and determined to be an issue of low safety significance (GREEN) based on an engineering analysis of the large early release frequency. This finding was a non-cited violation of NRC requirements.
Inspection Report# : 2001005*(pdf)*

Significance: G Jan 08, 2000
Identified By: NRC

Item Type: NCV NonCited Violation
FAILURE TO MEET THE TS REQUIREMENTS FOR STANDBY GAS TREATMENT SYSTEM.
On October 14, 1999, NYPA determined that the standby gas treatment system train B charcoal filter had been unable to meet the Technical Specification (TS) requirements for about six months. The failure to meet TS requirements was determined to have very low risk significance (GREEN) by the SDP because the changes in charcoal filter efficiency had little impact on the large early release frequency or magnitude. This failure to meet TS requirements was determined to be a Non-Cited Violation.
Inspection Report# : 1999010*(pdf)*

Significance: G Oct 18, 1999
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY VERIFY CONTAINMENT HYDROGEN/OXYGEN LEVELS.
NYPA reported in LER 50-333/99-005, that a surveillance test to measure the containment hydrogen and oxygen levels was not completed as required due to personnel error and an equipment failure. Because hydrogen and oxygen levels remained within specification, this event was determined to have very low risk significance. The failure to perform the technical specification required surveillance testing is a violation of NRC requirements. This issue was determined to be a non-cited violation. (Section 4OA4.1)
Inspection Report# : 1999008*(pdf)*

Significance: G Jul 17, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
ADMINISTRATIVE PROCEDURES PROBLEMS CAUSED OPERATOR NON-ADHERENCE
The inspectors identified a problem in a NYPA administrative procedure which resulted in operators not adhering to written operating procedures. This administrative procedure resulted in a misunderstanding by the licensed operators of the requirements of their licenses with regard to procedure compliance and of the requirements of 10CFR50.54(x). This issue was previously identified and was not adequately resolved by the licensee. The failure to take appropriate corrective actions following an NRC-identified deficiency is a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." Operators not complying with plant procedures could have resulted in the inoperability of plant safety systems. This potential inoperability of plant safety systems had a very low risk significance as determined by the significance determination process.
Inspection Report# : 1999006*(pdf)*

Emergency Preparedness

Significance: G Sep 30, 2000
Identified By: NRC
Item Type: FIN Finding
TECHNICAL SUPPORT CENTER NOT EFFECTIVE IN MONITORING PLANT CONDITIONS DURING EMERGENCY PREPAREDNESS DRILL.
Activities at the technical support center during an observation of an emergency preparedness drill were not effective in monitoring plant conditions and providing recommendations and support to the control room. Further, the drill observers and participants did not identify this as a drill discrepancy. This issue was determined to be a Green finding (of very low safety significance) using the SDP, because if left uncorrected this issue could result in operators missing or complicating mitigating actions during an actual plant event. No violation of requirements was identified. (Section 1EP6)
Inspection Report# : 2000006*(pdf)*

Occupational Radiation Safety

Significance: N/A Mar 31, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
WORKERS ENTERED A POSTED HIGH RADIATION AREA WITHOUT ADHERING TO HP REQUIREMENTS.
Technical Specification 6.11 requires that procedures shall be prepared consistent with 10 CFR 20 and shall be adhered to for all operations involving personnel exposure. Contrary to this requirement, on December 12, 2000, three workers entered a posted high radiation area without adhering to the requirements contained in procedures AP-07.06, High Radiation Area, and RP-OPS-02.02, Radiation Work Permit. Contrary to procedural requirements, the workers entered a high radiation area without first contacting the radiation protection department (per AP-07.06) or

subsequently contacting the radiation protection department upon receiving electronic dosimtere dose rate alarms while in the area (per RP-OPS-02.02). No actual or potential safety consequences resulted since the actual dose rate in the work area did not exceed 70 mr/hr and the individuals were in the area for less than 15 minutes. This failure to adhere to Entergy HP procedural requirements was treated as a non cited violation.
Inspection Report# : 2001003*(pdf)*

Significance: G Sep 30, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO MAINTAIN RADIATION SURVEY INSTRUMENTS CALIBRATED IN ACCORDANCE WITH 10 CFR 20.1501.
The licensee failed to ensure that portable survey instruments, used for the conduct of the radiation protection program, were calibrated annually as required. The licensee used an instrument, whose calibration period had expired to perform neutron dose rate measurements for personnel entries into the drywell. The failure to maintain the instrument within the required calibration frequency was caused by a misapplication of a 25% grace period. Upon reviewing for extent of condition, the licensee identified other instruments that were available for use but not calibrated within the current annual period. The issue was screened using the Occupational Radiation Safety SDP and was determined to be Green (of very low safety significance) since this finding did not result in exposure or reasonable potential for exposure in excess of regulatory limits, and did not compromise the licensee's ability to assess individual exposure. However, this failure to maintain portable survey instruments within the required calibration frequency was considered a non-cited violation of NRC requirements. (Section 2OS1)
Inspection Report# : 2000006*(pdf)*

Significance: G Sep 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO HYDROSTATICALLY TEST SELF CONTAINED BREATHING APPARATUS AIR CYLINDERS.
A Non-Cited Violation of 10 CFR 20.1703(c)(4)(vii) for failure to conduct triennial hydrostatic tests of eleven (11) self-contained breathing apparatus (SCBA) air cylinders as required by written maintenance procedures. The finding is greater than minor because, if left uncorrected, inadequately tested respiratory protection equipment could be used by personnel in the event of an emergency. The finding is of very low safety significance because unqualified equipment was not actually used; all of the affected air cylinders displayed the proper air pressure indicating that cylinders maintained the requisite integrity; a sufficient supply (in excess of requirements) was available for use; a small percentage of the available air cylinders were not tested; and, the cylinders were identified to be overdue a relatively short time beyond their three-year test interval. (Section 2OS3)
Inspection Report# : 2001009*(pdf)*

Significance: G Jul 17, 1999
Identified By: NRC
Item Type: FIN Finding
CONTROL ROD CHANGEOUT EXCEEDED PROJECTED DOSE
The actual collective dose for the control rod (CRD) changeout, performed during the 1998 refueling outage, exceeded the projected dose by greater than 50%. The initial dose projection only addressed ancillary tasks and did not include the dose (approximately 5 person-rem) for removing and installing the CRDs. Using the SDP, the dose accrued for CRD changeout (10.019 person-rem) represented an issue with very low risk significance, in that, the actual dose exceeded the projected dose (4.800 person-rem) by more than 50%, the three year rolling average for FitzPatrick was greater than 240 person-rem, actual job dose was greater than 10 person-rem but less than 60 person-rem, and this finding represented a single occurrence meeting the SDP criteria.
Inspection Report# : 1999006*(pdf)*

Public Radiation Safety

Significance: G Oct 18, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
THE SHIPMENT OF A CONTAMINATED PUMP WAS NOT PROPERLY CHARACTERIZED.
A contaminated pump was not evaluated for fixed and removable contamination on inaccessible surfaces prior to being shipped. The relevant procedure did not contain the appropriate level of detail to ensure compliance with the applicable regulation. This regulatory noncompliance had the potential for uncontrolled release of contaminated material but had very low risk significance because the issue did not involved package external radiation limits, package breach, the package certificate of compliance, burial site access, or emergency notifications. This issue was determined to

be a non-cited violation. (Section 2PS2)
Inspection Report# : 1999008*(pdf)*

Physical Protection

Significance:  Apr 01, 2000
Identified By: NRC
Item Type: FIN Finding
FAILURE OF MULTIPLE PORTAL METAL DETECTORS DURING TESTING
A surveillance test of search equipment at the access point identified a failure of all of the portal metal detectors. The inspectors concluded that the time that the equipment was not functioning was minimal based on a satisfactory test two days prior to the failure and observations of equipment performance just prior to the test. The significance of the finding (GREEN) was based upon the determination that the condition was neither predictable or easily exploitable, nor were there any previous similar events. No violation of regulatory requirements was identified. This finding was evaluated using the significance determination process and determined to be GREEN (very low safety significance).
Inspection Report# : 2000002*(pdf)*

Miscellaneous

Significance: N/A Aug 11, 2000
Identified By: NRC
Item Type: FIN Finding
FITZPATRICK STAFF FAMILIAR WITH THE PROGRAM FOR IMPLEMENTATION OF A SAFETY CONSCIOUS WORK ENVIRONMENT.
The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.
Inspection Report# : 2000011*(pdf)*

Significance: SL-IV Aug 11, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IDENTIFY CONDITIONS ADVERSE TO QUALITY.
A Severity Level IV, Non-Cited Violation of 10 CFR 50, Appendix B, Criterio XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.
Inspection Report# : 2000011*(pdf)*

Significance: SL-IV Aug 11, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO EVALUATE CONDITIONS ADVERSE TO QUALITY (DERs) FOR OPERABILITY.
A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifiations was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not condicted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power mointoring relay were not evaluted with respect to operability, and the subsequent operbility eavluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.
Inspection Report# : 2000011*(pdf)*

Significance: SL-IV Aug 11, 2000
Identified By: NRC
Item Type: NCV NonCited Violation

FAILURE TO TAKE IMMEDIATE CORRECTIVE ACTIONS AND/OR ACTIONS TO PREVENT RECURRENCE.
A severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.
Inspection Report# : 2000011*(pdf)*

Last modified : March 28, 2002