

FitzPatrick 2Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to comply with TS 3.8.1 required actions for one offsite circuit inoperable

An NRC-identified non-cited violation of Technical Specification (TS) limiting condition for operation (LCO) 3.8.1, "Electrical Power Systems - AC Sources - Operating," was identified for failure to comply with the LCO required actions for one offsite power circuit inoperable within the specified time requirements.

This issue is more than minor because it is associated with the initiating events cornerstone attribute of configuration control and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In accordance with IMC 609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the finding was determined to be of very low risk significance (Green) because as a transient initiator it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

Inspection Report# : [2004005\(pdf\)](#)**G****Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate procedure for RPV leak testing resulted in inadvertent reactor vessel level decrease

A self-revealing violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for failure to provide a procedure appropriate to the circumstances. Specifically, surveillance procedure ST-39H, "RPV System Leakage Test and CRD Class-2 Piping Inservice Test," did not include adequate precautions for reactor vessel level control. This resulted in operators draining 120 inches from the reactor vessel with the only on-scale level indicator out of service for testing.

This finding is more than minor because it is associated with the procedure quality and configuration control attributes of the initiating events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions while shutdown. In accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," dated May 25, 2004, the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation. The finding is associated with the cross cutting area of human performance because in addition to the inadequate procedure, it involved operators' failure to maintain adequate control of equipment status during operations in accordance with Entergy administrative procedure (AP)-19.01, "Conduct of Operations."

Inspection Report# : [2004005\(pdf\)](#)

Mitigating Systems

G**Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for 23MOV-14 seat leakage

An NRC-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failure to correct a condition adverse to quality involving high pressure coolant injection (HPCI) turbine steam supply isolation valve 23MOV-14 seat leakage. In November 2004 this resulted in 53 hours of unplanned HPCI system unavailability due to emergent corrective maintenance to address degradation of the valve disc and seat.

This issue is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability of systems that respond to initiating events. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the senior reactor analyst determined the finding to be of very low risk significance using a Phase 2 SDP evaluation.

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Transient Combustible Control Requirements for the Screenwell Not Met

The inspectors identified that transient combustible control requirements for resin storage in the screenwell house were not met. The weight and location of the resin exceeded administrative limits and a transient combustible evaluation (TCE) was not performed. The finding was of very low safety significance (Green) and resulted in a noncited violation of Technical Specification (TS) 5.4.1.d that requires fire protection program procedures be implemented.

The performance deficiency involved failure to comply with procedure requirements concerning storage of transient combustible material and ensuring that an engineering assessment was completed when specified.

The finding was more than minor because the quantity of combustible material incorrectly stored exceeded the limits of the screenwell smoke and hot gas analysis (See example 4.k in NRC Inspection Manual 0612, Appendix E). It was associated with the protection against external factors attribute of the mitigating systems cornerstone and negatively affected the objective of maintaining the reliability of the mitigating systems located in the scenewell house, the ESW and RHR service water pumps.

The finding had a human performance cross-cutting aspect because it involved personnel not following procedure instructions.

Inspection Report# : [2004004\(pdf\)](#)

Barrier Integrity

Significance:  Apr 02, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for SGT fan vibrations

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for Entergy's failure to adequately evaluate and correct a condition adverse to quality involving a degrading trend in vibration for the B standby gas treatment (SGT) fan assembly. In March 2005 this resulted in 35 hours of unplanned B SGT unavailability due to emergent corrective maintenance to address increasing vibration levels.

The issue was more than minor because it was associated with the operational capability and operations/maintenance performance attributes of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance of containment integrity to protect the public from radiological releases. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the Phase 1 screening for the containment barriers cornerstone resulted in a finding of very low risk significance (Green) because the finding only represented a degradation of the radiological barrier function provided by the SGT system.

Inspection Report# : [2005003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Aug 05, 2004

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The NRC team determined that Entergy was effective at identifying discrepant conditions at an appropriate threshold and entering them into the corrective action program. Once entered into the system, issues were typically prioritized appropriately and in a timely fashion; and were properly evaluated commensurate with the safety significance. Overall, the evaluations reasonably identified the causes of the problem, the extent of the condition, and provided for corrective actions to address the causes. However, the team noted some minor instances where long-standing and recurring equipment problems were not effectively evaluated and corrected in a timely fashion. On the basis of interviews conducted, the team determined that plant staff personnel were familiar with and utilized the corrective action program to identify problems.

Inspection Report# : [2004006\(pdf\)](#)

Last modified : August 24, 2005