

FitzPatrick 3Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate AOP Resulted In Reactor Trip

A self-revealing NCV of Technical Specification (TS) 5.4, "Procedures", occurred when Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, abnormal operating procedure (AOP)-21, "Loss of UPS," did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of uninterruptible power supply. This resulted in an automatic reactor scram on September 14, 2005, due to low reactor vessel water level. Entergy revised the procedure as a corrective action for this violation.

The finding is greater than minor because it affected the procedure adequacy attribute of the initiating event cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and is not potentially risk significant due to external events. This finding is associated with the human performance cross-cutting area in that Entergy failed to maintain a procedure appropriate to the circumstances. Specifically, AOP-21 did not include adequate instructions for restoring automatic feedwater level control following a momentary loss of UPS.

Inspection Report# : [2005005\(pdf\)](#)**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-Revealing

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

Significance:  Jul 01, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Control of West Cable Tunnel Cooler 67E-11

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," because Entergy did not maintain adequate design control of the west cable tunnel unit cooler (UC) 67E-11 to ensure that it would perform its safety-related function under design basis conditions. Specifically, Entergy did not adequately evaluate the ability of the cooler to remove its design basis heat load with 22 tubes plugged and the maximum allowable ultimate heat sink temperature of 85 degrees Fahrenheit (F).

The finding is greater than minor because it is associated with the mitigating system cornerstone attributes for design control and equipment performance. It affects the mitigating system cornerstone objective to ensure the availability, reliability and capability of systems and components that are required to power safety-related loads for safe shutdown and accident mitigation. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it is a design deficiency confirmed not to result in a loss of function per NRC Generic Letter 91-18. This finding is documented in Entergy's corrective action program as CR-2005-02467.

Inspection Report# : [2005004\(pdf\)](#)

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\(pdf\)](#)

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

Last modified : November 30, 2005