September 18, 2002

Mr. Theodore Sullivan
Vice President - Operations
Entergy Nuclear Northeast
James A. FitzPatrick Nuclear Power Plant
Post Office Box 110
Lycoming, NY 13093

SUBJECT: **FITZPATRICK - NRC PROBLEM IDENTIFICATION & RESOLUTION INSPECTION REPORT 50-333/02-006**

Dear Mr. Sullivan:

On August 30, 2002, the NRC completed a team inspection at the James A. FitzPatrick Nuclear Power Plant. The enclosed inspection report documents the inspection findings, which were discussed with you and members of your staff during an exit meeting conducted by telephone on September 9, 2002.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations, and the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample reviewed, the team concluded that, in general, problems were properly identified, evaluated, and corrected. However, there were two green findings identified by the inspectors which were associated with the inadequacy of operability evaluations for conditions adverse to quality. The first finding was the failure to properly evaluate the condition report (CR) written after the "B" emergency service water (ESW) pump failed a surveillance test. Numerous FitzPatrick personnel failed to recognize that the "B" ESW pump should have been declared inoperable after the pump failed the Technical Specification Surveillance Requirement (TSSR). The second finding was related to the failure to properly evaluate for operability suspect Agastat relays in the emergency diesel generator sequencer circuit for the residual heat removal (RHR) pumps. Testing of the relays subsequently identified that one out of four relays was outside the TSSR acceptable tolerance, which rendered the "D" RHR pump inoperable.

Both of these findings were determined to be violations of NRC requirements. However, because of their very low safety significance (Green) and because they have been entered into your corrective action program, the NRC is treating the two violations as non-cited violations, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny either of these non-cited violations, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC, 20555-0001, with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC, 20555-0001; and the NRC Resident Inspector at the James A. FitzPatrick Nuclear Power Plant.

In accordance with 10CFR2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web-site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Reading Room).

Sincerely,

/RA/

David C. Lew, Chief
Performance Evaluation Branch
Division of Reactor Safety

Docket No. 50-333
License No. DPR-59

Enclosure: Inspection Report 50-333/02-006

cc w/encl:
J. Yelverton, CEO, Entergy Operations
B. O'Grady, General Manager, Entergy Nuclear Operations
J. Knubel, VP Operations Support
H. Salmon, Director of Oversight
A. Halliday, Licensing Manager
M. Kansler, COO, Entergy
D. Pace, VP Engineering
J. Fulton, Assistant General Counsel
Supervisor, Town of Scriba
J. Tierney, Oswego County Administrator
C. Donaldson, Esquire, Assistant Attorney General, New York Dept. of Law
P. Eddy, Electric Division, Department of Public Service, State of New York
W. Flynn, President, New York State Energy Research & Development Authority
S. Lousteau, Treasury Department
T. Judson, Central New York Citizens Awareness Network

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G. Meyer, DRP
R. Barkley, DRP
R. Urban, ORA
C. Bixler, DRP
F. Congel, OE
S. Figueroa, (SLF)
H. Neih, RI EDO Coordinator
S. Richards, NRR
G. Vissing, PM, NRR
R. Clark, Backup PM, NRR
T. Frye, NRR
C. See, NRR

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REGION I

Docket No:	50-333
License No:	DPR-59
Report No:	50-333/02-006
Licensee:	Entergy Nuclear Northeast Post Office Box 110 Lycoming, NY 13093
Facility:	James A. FitzPatrick Nuclear Power Plant
Location:	268 Lake Road Scriba, New York 13093
Dates:	August 12 - 30, 2002
Inspectors:	B. S. Norris, Senior Reactor Inspector G. V. Cranston, Reactor Inspector W. E. Holland, contractor
Approved by:	David C. Lew, Chief Performance Evaluation Branch Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000333-02-06; on August 12-30, 2002; James A. FitzPatrick Nuclear Power Plant; biennial inspection of the identification and resolution of problems. Two violations were identified in the area of operability evaluations of identified conditions adverse to quality.

The inspection was conducted by two regional inspectors and one contractor. Two green findings of very low safety significance were identified during the inspection and were classified as non-cited violations. The significance of most findings is indicated by their color (green, white, yellow, red) using Inspection Manual Chapter 0609, "Significance Determination Process (SDP)." The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

Identification and Resolution of Problems

The NRC inspection team concluded that, in general, problems were properly identified, evaluated, and corrected. The threshold for entering items into the corrective action program was low, conditions were evaluated for the appropriate corrective action, and the effectiveness of the corrective actions appeared to be adequate. Audits and self-assessments identified adverse conditions and negative trends, and the results of the self-assessments and audits were entered them into the corrective action program. There were no significant conditions identified by the inspectors that had not been already found by the auditors or self-assessments.

However, there were two green findings identified by the inspectors associated with the inadequacy of operability evaluations for identified conditions adverse to quality. Both findings were determined to be violations of NRC requirements.

Cornerstone: Mitigating Systems

Green A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because licensee personnel failed to identify that, during a surveillance test, the "B" emergency service water (ESW) pump was inoperable after the flow for the "B" train of ESW was below the required value in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the licensee had erroneously concluded that the pump was operable based on a non-safety system cooled by the "B" train of ESW being tagged out of service.

This finding is greater than minor and could become a more significant safety concern because operators failed to recognize inoperable equipment during surveillance testing. The ESW system provides cooling water to the emergency diesel generators (EDGs) and the room coolers for the emergency core cooling system (ECCS) pumps. The failure of ESW is applicable to the mitigating systems cornerstone, because the failure of the ESW system could affect the safety function of the EDGs and/or the ECCS pumps. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety

significance because the low flow condition for the “B” ESW pump was not of significant magnitude to preclude the system from meeting its safety function. (Section 4OA2.b(2)(a))

Green A violation of 10CFR50, Appendix B, Criterion XVI, (Corrective Action), dispositioned as a non-cited violation, was identified because FitzPatrick personnel failed to adequately evaluate the operability of the emergency diesel generator (EDG) Agastat sequence timers controlling the residual heat removal (RHR) pumps. The RHR timers were of the same type and surveillance frequency as the core spray (CS) timers which had failed their Technical Specification required surveillance test. When the RHR timers were tested, the “D” RHR pump timer failed to meet the value listed in the Technical Specification Surveillance Requirement. During the inspection, the NRC inspectors identified that the FitzPatrick basis for operability failed to recognize that the surveillance frequency for the RHR timers had been extended from 6 months to 24 months, a contributing factor for the CS timers failing.

This finding is greater than minor and could have become a more significant safety concern because personnel failed to perform adequate operability determinations for suspect conditions adverse to quality. The Agastat timers are used to sequence emergency equipment and system loads onto the EDGs at pre-determined intervals, in order to minimize the potential for damage to the EDGs. The failure of an RHR Agastat timer for the EDG sequencer timer is applicable to the mitigating systems cornerstone, because the failure of timers could result in multiple loads sequencing onto the EDG at the same time, which could affect the reliability of the EDGs or the loads supplied by the EDGs. This finding was evaluated using the NRC Significance Determination Process, and was screened as having very low safety significance because the out-of-tolerance condition for the “D” RHR pump timer was not of significant magnitude to preclude the system from meeting its safety function. (Section 4OA2.b(2)(b))

REPORT DETAILS

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

a. Effectiveness of Problem Identification

(1) Inspection Scope

The inspection team reviewed the procedures describing the corrective action process at the James A. FitzPatrick Nuclear Power Plant. Shortly before the start of the inspection, the site converted to a new corrective action reporting system called the paperless condition reporting system (PCRS). This conversion was a consequence of the transition in ownership and operation of the plant from the New York Power Authority to Entergy Nuclear Northeast. In addition to the condition reports (CRs), the corrective action program encompassed maintenance related deficiencies, which were initiated on problem identification (PID) reports. The team reviewed a sample of CRs and PIDs to determine the threshold for identification of problems. The team reviewed shift logs, control room deficiencies and operator work-arounds, system health reports, completed surveillance tests, work requests, temporary modifications, operating experience reviews, and procedures related to specific issues. In addition, the team interviewed staff and management to determine their understanding of the corrective action program and the mechanics of the recently implemented PCRS. The specific documents reviewed and referenced during the inspection are listed in the Attachment to this inspection report.

The team reviewed a sample of quality assurance (QA) audits and surveillances, and departmental self-assessments in the areas of operations, maintenance, engineering, radiation protection, security, emergency preparedness, training, and the corrective action program itself. The review was to determine if assessment findings were entered into the FitzPatrick corrective action program, and if the corrective actions were completed to resolve identified program deficiencies. The team also conducted several plant walk-downs of safety-related, risk significant areas to verify that observable system equipment and plant material adverse conditions were identified and entered into the corrective action program.

(2) Findings

Overall, the inspectors determined that the FitzPatrick staff was effective in identifying problems and entering them into the corrective action program. The threshold for identification of problems was low, as evidenced by the approximate 500 low-level items on the elective maintenance list. In addition, the self-assessments identified adverse trends, which were subsequently entered into the corrective action program. The QA audits were self-critical and consistent with the team's findings; in that, the inspectors identified no significant issues that had not already been found by the QA auditors.

b. Prioritization and Evaluation of Issues

(1) Inspection Scope

The inspectors reviewed the CRs and PIDs listed in the Attachment to assess whether the licensee adequately prioritized and evaluated the identified problems. The review included the causal assessment of each issue (a root cause analysis, an apparent cause evaluation, or an estimate of the most probable cause); and for significant conditions adverse to quality, the extent of condition and determination of corrective actions to preclude recurrence. The inspectors also evaluated the documents listed in the Attachment for operability, reportability, and Maintenance Rule reliability and unavailability.

The team reviewed the backlog of maintenance and engineering issues to determine if issues were properly prioritized, and if individually or collectively they represented an increased risk due to the delay of corrective actions. The team also reviewed the status and plans to correct equipment problems identified through the system health reports and the Maintenance Rule. The team attended the daily screening and management meetings to evaluate their ability: (1) to assess CR significance, (2) to consider if a PID required a CR, and (3) to identify if the initial determination of operability and reportability were correct.

The team observed the onsite Plant Operations Review Committee (PORC) and the offsite Station Review Committee (SRC), and reviewed the minutes of past meetings, to determine if during their reviews they were critical of the site's activities.

(2) Findings

The team noted that the majority of the CRs reviewed were properly classified as to significance level ("A" through "D"). Significant conditions adverse to quality were classified as an "A" and received a formal root cause analysis (RCA), and an extent-of-condition review. The RCAs reviewed were thorough, determined the root cause and contributing causes, and recommended corrective actions correlated to each identified cause; as required, corrective actions were identified to preclude recurrence. The overall backlog of issues appeared reasonable and properly evaluated for risk both individually and collectively. The majority of the CRs were for minor issues and were classified as level "D" CRs, usually corrected-on-the-spot and closed to trending. The remaining CRs were level "B" and "C" and received the appropriate depth of causal analysis.

Notwithstanding, the team identified two instances, related to surveillance tests (STs), where the FitzPatrick staff had not adequately evaluated conditions adverse to quality with respect to the operability of equipment required by the FitzPatrick Technical Specifications (TS).

(a) Emergency Service Water

Green. A non-cited violation of 10CFR50, Appendix B, Criterion XVI (Corrective Action), was identified for failure to adequately evaluate a condition adverse to quality regarding a failed surveillance test for the emergency service water (ESW) system, which resulted in the failure to declare the "B" ESW pump inoperable.

The inspectors reviewed CR-JAF-2001-1046, which noted that the "B" ESW pump failed to meet TS and inservice test (IST) acceptance criteria for flow, during a March 2001 surveillance test (ST-8Q). During review of the CR, the inspectors noted that the "B" ESW pump was not declared inoperable. The inspectors reviewed the completed ST-8Q, and noted the operators considering the "B" ESW pump to be operable based on the fact that a valve (46(70)-SWS-26) was tagged out of service for maintenance. Step 4.7 of ST-8Q, a prerequisite for the ST, stated that the ESW system was lined-up per OP-21; the step further stated that exceptions were permitted if they did not impact the test performance. The inspectors noted that the step was signed off as complete, even though the valve was tagged out of service, and listed in the remarks section of the ST. The valve is for the control room chiller, a non-safety related load supplied by the "B" train of ESW. The step required interpretation by the operator and the Shift Manager as to what would affect the test. The inspectors considered this step to be a weakness in the procedure; in that it allowed for inconsistent initial conditions, which could result in inaccurate or irrelevant IST and TS surveillance requirement (TSSR) test data. There was no violation of NRC requirements. This was entered into the FitzPatrick corrective action program as CR-JAF-2002-3282.

During the March 2001 ST, the flow for the "B" ESW loop was measured as 1480 gpm [gallons per minute]. This was below the TSSR value of 1500 gpm. The reactor operator (RO) and the senior reactor operator (SRO), both licensed positions, recognized that the acceptance criteria was not met; they both checked the applicable block in the Acceptance Verification section of the ST. However, neither individual recognized that the failed TS surveillance test required that the "B" ESW pump be declared inoperable. The shift initiated CR-JAF-2001-1046, as required by the ST, noting that the pump was operable; the CR screening committee and the management review also failed to recognize that the "B" ESW pump was inoperable.

This finding is greater than minor and could become a more significant safety concern if operators fail to recognize inoperable equipment during surveillance testing. The ESW system provides cooling water to the emergency diesel generators (EDGs) and the room coolers for the emergency core cooling system (ECCS) pumps. The failure of ESW is applicable to the mitigating systems cornerstone, in that the failure of the ESW system could affect the safety function of the EDGs and/or the ECCS pumps. This finding was evaluated using Phase 1 of the NRC Significance Determination Process (SDP), and was screened as having very low safety significance (Green) because the low flow condition for the "B" ESW pump was not of significant magnitude to preclude the system from meeting its safety function.

10CFR50, Appendix B, Criterion XVI, requires that conditions adverse to quality be promptly identified and corrected. Contrary to this requirement, in March 2001, during the performance of ST-8Q, the "B" ESW pump flow was less than the value specified in

TSSR 3.11.D. FitzPatrick personnel did not adequately evaluate the failure to satisfy a TSSR, which resulted in the failure to declare the affected equipment inoperable. However, because of the very low safety significance, and because the issue was entered into the FitzPatrick corrective action program as CR-JAF-2002-3279, it is being treated as a non-cited violation (NCV) consistent with Section VI.A.1 of the NRC Enforcement Policy. **(NCV 50-333/2002-006-01)**

(b) Residual Heat Removal Agastat Timers

Green. A non-cited violation of 10CFR50, Appendix B, Criterion XVI (Corrective Action), was identified for failure to properly evaluate a condition adverse to quality regarding suspect Agastat timers in the EDG sequencer for the residual heat removal (RHR) pumps. This resulted in a failure to take timely corrective action to test the relays, which caused the licensee to fail to promptly identify that the "D" RHR Agastat timer was outside of the TSSR acceptance criteria.

On July 22, 2002, during the performance of ST-3J, "Core Spray Initiation Logic System Functional Test," FitzPatrick personnel discovered that the as-found value for the Agastat timers for sequencing the core spray (CS) pumps onto the EDG did not meet the acceptance criteria specified in the TSSR. The staff initiated CR-JAF-2002-2713 and CR-JAF-2002-2721, as required by the ST.

During the inspection, the team was discussing the CS timer failures with FitzPatrick engineering personnel. FitzPatrick staff stated that the reason for the failures was probably due to the TSSR frequency of testing the timers changed from 6 months to 24 months. This was the first time that the timers had been tested at the new frequency. The inspectors asked if other Agastat timers had a testing interval of 24 months. They were informed that the timers for the four RHR pump start timers were the same type timer but had not yet been tested at the 24 month frequency. The inspectors requested a copy of the operability determination for the RHR timers; they were told that the issue had been discussed with the operations shift personnel the same day that the CS timers had failed, but nothing had been documented. On August 15, 2002, the team met with engineering and operations personnel to further discuss the operability of the RHR timers. FitzPatrick engineering personnel informed the team that the drift associated with the CS timers would not occur for the RHR timers because the RHR Agastat relays used a different range.

The inspectors considered the basis for operability of the RHR timers to be inadequate, based on: (1) both of the CS timers had failed, (2) this was the first time that the CS timers had been tested after the surveillance frequency was changed from 6 months to 24 months, and (3) the RHR timers surveillance frequency had also been extended to 24 months and had not been tested for almost 2 years. The RHR timers were scheduled to be tested in mid-September 2002; after discussions with the NRC, FitzPatrick management rescheduled the ST to August 24th; the "D" RHR Agastat timer was found to be outside the acceptance criteria.

This finding is greater than minor and could have become a more significant safety concern if personnel fail to perform adequate operability determinations for suspect

conditions adverse to quality. The Agastat timers are used to sequence emergency equipment and systems onto the EDGs at pre-determined intervals, to minimize the potential for damage to the EDGs. The failure of an RHR Agastat timer for the EDG sequencer timer is applicable to the mitigating systems cornerstone, in that the failure of timers could result in multiple loads sequencing onto the EDG at the same time, which could affect the reliability of the EDGs or the loads supplied by the EDGs. This finding was evaluated using Phase 1 of the NRC SDP, and was screened as having very low safety significance (Green) because the out-of-tolerance condition for the "D" RHR pump timer was not of significant magnitude to preclude the system from meeting its safety function.

10CFR50, Appendix B, Criterion XVI, (Corrective Action) requires, in part, that measures be established to ensure that conditions adverse to quality are promptly identified and corrected. Contrary to this requirement, FitzPatrick personnel failed to properly evaluate the condition for operability, which caused a failure to promptly test the RHR relays, which resulted in a failure to promptly identify a condition adverse to quality (the "D" RHR pump Agastat timer exceeding the TSSR value). However, because of the very low safety significance, and because the issue was entered into the FitzPatrick corrective action program (CR-JAF-2002-3077, -3211, and -3462), it is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy. **(NCV 50-333/2002-06-02)**

c. Effectiveness of Corrective Actions

(1) Inspection Scope

The inspectors reviewed the corrective actions associated with the selected CRs to determine whether the actions had addressed the identified causes of the problems. The team also reviewed the licensee's timeliness for implementing the corrective actions, and their effectiveness in precluding recurrence for significant conditions adverse to quality. The team also reviewed the non-cited violations issued since the last inspection of the FitzPatrick corrective action program to determine if issues placed in their program had been properly evaluated and corrected.

(2) Findings

Overall, the inspectors determined that the corrective actions were effective for the identified condition; and as applicable, to prevent recurrence of the problem, or similar problems. The team noted that the FitzPatrick corrective action program requires effectiveness reviews for significant conditions, and includes the effectiveness review as the final corrective action on those CRs.

d. Assessment of Safety Conscious Work Environment

(1) Inspection Scope

During the inspection, the team interviewed plant staff to determine if conditions existed at the site which would result in personnel being hesitant to raise safety concerns to FitzPatrick management and/or the NRC.

(2) Findings

No findings were identified.

4OA6 Meetings

a. Exit Meeting Summary

On September 9, 2002, the team presented the inspection results, via telephone, to Mr. T. Sullivan, and members of his staff. No proprietary material examined during the inspection was retained by the inspectors.

Attachment: Partial List of Personnel Contacted
Items Opened & Closed
List of Documents Reviewed
List of Acronyms

ATTACHMENT

A. PARTIAL LIST OF PERSONS CONTACTED

Entergy:

S. Anderson	Supervisor, Balance of Plant System Engineering
V. Bhardwaj	Manager, Engineering Programs & Component Engineering
S. Bono	Manager, System Engineering
B. Brunham	System Engineer
J. Haley	Security Manager
B. Horning	Plant Program Supervisor
A. Khanifan	Engineering Design Manager
O. Limpias	Director, Site Engineering
F. Lukaczyk	Operations Support Supervisor - CA Assessor
W. Maguire	Maintenance Manager
A. Mitchell	Design Engineering Supervisor
L. Normandeau	Maintenance Rule Coordinator
B. O'Grady	General Manager, Plant Operations
J. Pechacek	Fire Protection & Safety Coordinator
R. Pike	Senior Reactor Operator, Fix-It-Now (FIN) Team
R. Plasse	Regulatory Compliance Manager (acting)
K. Pushee	Radiation Protection Manager
R. Rottenberk	Supervisor, Mechanical, FIN Team
D. Ruddy	Manager, CA&A
P. Russell	Operations Manager
T. Sullivan	Vice President, Operations
D. Torbitt	Assistant Operations Manager
D. Vandermark	Supervisor, Engineering
D. Wallace	Quality Assurance Manager
A. Zaremba	Director, Safety Assessment

Nuclear Regulatory Commission:

D. Dempsey	Resident Inspector
D. Lew	Branch Chief, Performance Evaluation Branch, Region I
R. Rasmussen	Senior Resident Inspector

B. ITEMS OPENED & CLOSED

50-333/2002-06-01	NCV	Failure to identify that the "B" ESW pump was inoperable after results of a TS required surveillance test were less than the value in TSSR 3.11.D (Section 4OA2.b(2)(a))
50-333/2002-06-02	NCV	Inadequate operability evaluation for suspect Agastat timers resulted in failure to promptly identify failed timer for the "D" RHR pump (Section 4OA2.b(2)(b))

C. LIST OF DOCUMENTS REVIEWED

Procedures:

AP-01.01	Plant Operating Review Committee, Revision 14
AP-02.06	Procedure Use and Adherence, Revision 14
AP-03.11	Operability & Reportability Determinations, Revision 9
ENN-DC-136	Temporary Alterations, Revision 0
ENN-LI-102, Supp	Corrective Action Process Desk Guide, Revision 2
ENN-LI-102	Corrective Action Process, Revision 2
ENN-LI-104	Assessment Process, Revision 2
OP-21	Emergency Service Water, Revision 30
QAP-16.1 (J)	Processing Quality Assurance Condition Reports, Corrective Actions, and Action Items, Revision 8
QAP-18.1 (J)	Quality Assurance Audit Program, Revision 9
QAP-18.2 (J)	Quality Assurance Surveillance Program, Revision 3
ST-3J	Core Spray Initiation Logic System Functional Test, Revision 31
ST-8Q	Testing of the Emergency Service Water System (IST)*, Revision 24

Non-Cited Violations:

NCV 2000-11-02	Failure to Identify Conditions Adverse to Quality
NCV 2000-11-03	Failure to Evaluate Conditions Adverse to Quality for Operability
NCV 2000-11-04	Failure to Take Immediate Corrective Actions and/or Actions to Prevent Recurrence
NCV 2001-05-01	Inadequate Corrective Actions to Prevent Recurring LLRT Failures of MSIVs
NCV 2001-07-01	Failure to Properly Implement Procedures for Personnel Entry into a Locked High Radiation Area
NCV 2001-09-01	Failure to Perform Extent of Condition Review for Deficient Cross-tie Hoses
NCV 2001-09-02	Inadequate Post-maintenance Tests
NCV 2001-09-03	Failure to Determine Reference Values Following Pump Replacement
NCV 2001-09-04	Failure to Hydrostatically Test Self-contained Breathing Apparatus Air Cylinders
NCV 2001-09-05	APRM/RBM Technical Specifications Not Followed
NCV 2001-10-01	Safety Relief Valve Setpoint Drift, Included LER 50-333/01-005-00
NCV 2001-13-01	Failure to Adequately Review a Design Change Implemented by a Temporary Modification
NCV 2002-03-01	Inadequate Preventive Maintenance of the Startup Feedwater Control Valve
NCV 2002-03-02	Inadequate Corrective Action for Safety-Related Temperature Control Valves

Quality Assurance Audits:

A01-02J	Industry Operating Experience Review Program Audit
A01-03J	Offsite Dose Calculation Manual and Radiological Effluent Technical Specifications
A01-05J	Special Processes
A01-06J	Fitness for Duty, Access Authorization, and Personnel Access Data System
A01-07J	Entergy Nuclear QA Activities at the J. A. FitzPatrick Nuclear Power Plant
A01-08J	JAF Physical Security Program
A01-12J	Technical Specifications, Limiting Conditions of Operations, Surveillance Requirements, Administrative Controls, and Facility Operating License
A01-14J	Emergency Preparedness Program Audit
A01-15J	Results of Actions to Correct Deficiencies
A01-16J	Results of Actions to Correct Deficiencies
A02-01J	Training and Qualification of the Facility Staff
A02-03J	Design Control
A02-04J	Audit of Process Control Program, Radiological Effluent Technical Specifications, and Regulatory Guide 121

Self-Assessments:

---	Quarterly Integrated Self-Assessment & Trend Reports: 4th Quarter 2001, 1st Quarter 2002, 2nd Quarter 2002
JAF-02-3095	Engineering Confirmation of Operability
JCA&A-02-004	Fourth Quarter 2001 Operating Experience Report
JCA&A-02-010	First Quarter 2002
JENG-01-018	Maintenance Rule Improvement Action Plan
JENG-02-005	Recirculation Flow Control System Maintenance Rule Action Plan
JENG-02-201	First Quarter 2002 Roll Up Assessment
JOPS-02-022	Focused Self Assessment Report 0P.2, Conduct of Operations, Shift Turnover
JORG-02-001	Corrective Action & Assessments Fourth Quarter 2001
JORG-02-002	Focused Self Assessment of DER Closeout Phase
JRP-02-057	First Quarter 2002 Radiation Protection Program Roll-Up
JRP-02-102	Second Quarter 2002 Radiation Protection Program Roll-Up
JTS-00-011	Emergency Service Water Maintenance Rule Action Plan
JTS-99-007	AOV Program Action Plan
JTS-99-013	System 31/35 AOV's Maintenance Rule Action Plan

Operability Reviews:

JENG-REO-1999-1666	Penetration Seals for High Energy Line Break
JENG-REO-2001-0047	Operability for RCIC EGM Control Box Capacitor
JENG-REO-2001-0050	"B" ESW Loop Flow Less than Required During ST-8Q
JENG-REO-2002-1606	RHRSW Keep Full Supply Check Valve Failed PWT

Attachment (cont.)

Condition Reports: (* Denotes CR generated as a result of this inspection)

1997-0284	2001-3053	2001-3927	2001-4316	2002-0484	2002-1685
1999-1376	2001-3058	2001-3934	2001-4408	2002-0492	2002-1687
1999-1377	2001-3062	2001-3999	2001-4486	2002-0512	2002-1763
2000-1930	2001-3127	2001-4006	2001-4495	2002-0551	2002-1765
2000-3195	2001-3131	2001-4008	2001-4570	2002-0615	2002-1812
2000-3222	2001-3132	2001-4009	2001-4596	2002-0630	2002-1858
2000-4862	2001-3156	2001-4010	2001-4614	2002-0645	2002-1860
2000-5158	2001-3202	2001-4011	2001-4683	2002-0717	2002-1866
2001-0470	2001-3210	2001-4012	2001-4688	2002-0724	2002-1873
2001-0817	2001-3218	2001-4014	2001-4710	2002-0729	2002-1880
2001-1255	2001-3224	2001-4015	2001-4722	2002-0866	2002-1892
2001-1586	2001-3247	2001-4016	2001-4822	2002-0953	2002-1896
2001-2002	2001-3259	2001-4017	2001-4828	2002-0957	2002-1909
2001-2070	2001-3302	2001-4018	2001-4906	2002-1014	2002-1934
2001-2150	2001-3319	2001-4019	2001-4976	2002-1030	2002-1943
2001-2152	2001-3446	2001-4020	2001-5003	2002-1031	2002-1958
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2001-2166	2001-3489	2001-4022	2002-0030	2002-1114	2002-2030
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2001-2223	2001-3644	2001-4028	2002-0112	2002-1175	2002-2076
2001-2319	2001-3650	2001-4035	2002-0132	2002-1187	2002-2713
2001-2331	2001-3655	2001-4036	2002-0174	2002-1190	2002-2721
2001-2370	2001-3684	2001-4056	2002-0189	2002-1203	2002-2998
2001-2381	2001-3761	2001-4058	2002-0205	2002-1279	2002-3014
2001-2396	2001-3772	2001-4078	2002-0210	2002-1326	2002-3044
2001-2661	2001-3793	2001-4200	2002-0239	2002-1374	2002-3057
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PID-96708	PID-96999	PID-97097	PID-98814	PID-99753
PID-96844	PID-97028	PID-97141	PID-99595	PID-99782
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D. ABBREVIATIONS

CA&A	Corrective Action and Assessment
CFR	Code of Federal Regulations
CR	Condition Report
CS	Core Spray
DER	Deviation/Event Report (predecessor to the CR system)
ECCS	Emergency Core Cooling System
EDG	Emergency Diesel Generator
ESW	Emergency Service Water
gpm	gallon per minute
JAF	James A. FitzPatrick Nuclear Power Plant
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PCRS	Paperless Condition Report System
PI&R	Problem Identification and Resolution
PID	Problem Identification Report
PORC	Plant Operations Review Committee
QA	Quality Assurance
RCA	Root Cause Analysis
REO	Reasonable Expectation of Operability
RHR	Residual Heat Removal
SDP	Significance Determination Process
SRC	Station Review Committee
ST	Surveillance Test
TM	Temporary Modification
TS	Technical Specification
TSSR	Technical Specification Surveillance Requirement
WR	Work Request