# FitzPatrick
# 1Q/2015 Plant Inspection Findings

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## Initiating Events

**Significance: N/A** Sep 30, 2014
Identified By: NRC
Item Type: NCV Non-Cited Violation
**Failure to Notify NRC Within 30 Days of Medical Changes for Licensed Operators**
The inspectors identified a Severity Level (SL) IV NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.74, "Notification of Change in Operator or Senior Operator Status." Specifically, on three occasions, Entergy staff did not notify the NRC of a change in the medical status of a licensed operator within 30 days of learning of the diagnosis. These issues were entered into the corrective action program (CAP) as condition report (CR)-JAF-2014-02227 and CR-JAF-2014-02304.

The inspectors determined that Entergy's failure to notify the NRC of licensed operator medical status changes as described above within 30 days was a performance deficiency that was within Entergy's ability to foresee and correct and should have been prevented. Because the issue had the potential to affect the NRC's ability to perform its regulatory function, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.4.d.1(b) from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation because Entergy staff did not communicate licensed operator permanent medical status changes within the 30 day reporting requirement for three licensed operators. In accordance with IMC 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.
Inspection Report# : 2014004 *(pdf)*

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## Mitigating Systems

**Significance: N/A** Dec 31, 2014
Identified By: NRC
Item Type: NCV Non-Cited Violation
**Untimely 10 CFR 50.72 Notification of a Secondary Containment System Functional Failure**
The inspectors identified a Severity Level (SL) IV non-cited violation (NCV) of Title10 of the Code of Federal Regulations (10 CFR) 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," because unplanned inoperability of the secondary containment system was not reported to the NRC within eight hours of the occurrence, as required by 10 CFR 50.72(b)(3)(v), "Event or Condition that Could Have Prevented Fulfillment of a Safety Function." Specifically, while restoring the normal reactor building ventilation system to service following maintenance, reactor building-to-ambient differential pressure dropped below the Technical Specification (TS) required minimum value of 0.25 inches of vacuum water gauge and therefore caused the secondary containment system to be inoperable. However, FitzPatrick staff did not promptly recognize this as a condition reportable under 10 CFR 50.72. As corrective action, FitzPatrick staff reported the condition to the NRC in accordance with 10 CFR 50.72 (b)(3)(v) and entered it into the corrective action program (CAP) as condition report (CR)-JAF-2014-06498.

The inspectors determined that the failure to inform the NRC of the secondary containment system inoperability within eight hours in accordance with 10 CFR 50.72(b)(3)(v) was a performance deficiency that was reasonably

within Entergy's ability to foresee and correct. The inspectors evaluated this performance deficiency in accordance with the traditional enforcement process because the issue impacted the regulatory process, in that a safety system functional failure was not reported to the NRC within the required timeframe, thereby delaying the NRC's opportunity to review the matter. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that the violation was a SL IV (more than minor concern that resulted in no or relatively inappreciable potential safety or security consequence) violation, because Entergy personnel failed to make a report required by 10 CFR 50.72 when information that the report was required had been reasonably within their ability to have identified. In accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," traditional enforcement issues are not assigned cross-cutting aspects.

Inspection Report# : 2014005 *(pdf)*

**Significance:** G Dec 31, 2014
Identified By: NRC
Item Type: NCV Non-Cited Violation
**TS Actions for Inoperable ECCS Not Performed Within the TS Allowed Completion Time**
The inspectors identified a Green NCV for two violations of TS 3.5.1, "ECCS [emergency core cooling systems] - Operating," associated with the non-functionality of east crescent area ventilation and cooling (CAVC) subsystem unit cooler 66UC-22H. Specifically, during the periods May 5 through May 21, 2010, and March 15 through March 25, 2011, the Technical Requirements Manual (TRM) requirements for east crescent unit cooler operability were not satisfied for longer than the allowed outage time (AOT), which caused the ECCS in the east crescent to become inoperable and remain so for longer than the TS AOT without completion of the required plant mode changes. As immediate corrective action, Entergy personnel reconditioned the fan motor contactor for the affected unit cooler to obtain satisfactory low voltage pickup response. The issue was entered into Entergy's CAP as CR-JAF-2012-00584 and CR-JAF-2012-02288.

The finding was 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, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the unsatisfactory low voltage response of the 66UC-22H fan motor contactor, along with the unavailability of another east CAVC unit cooler due to maintenance, could have degraded the capability of ECCS systems in the east crescent area during an accident concurrent with degraded voltage conditions. In light of FitzPatrick staff's determination that there was reasonable assurance that the remaining three operable unit coolers would have been capable of removing required post-accident heat loads, the inspectors determined that the finding was of very low safety significance (Green) in accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent the actual loss of a safety function of a single train for greater than its TS AOT, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Resolution, because FitzPatrick staff did not take effective corrective actions to address the low voltage pickup issue in a timely manner commensurate with its safety significance [P.3].

Inspection Report# : 2014005 *(pdf)*

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# Barrier Integrity

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# Emergency Preparedness

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# Occupational Radiation Safety

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# Public Radiation Safety

**Significance:** G Jun 30, 2014
Identified By: NRC
Item Type: NCV Non-Cited Violation
**Failure to Properly Ship RAM-QC**
Green. The inspectors identified a Green NCV of 10 CFR 71.5, “Transportation of Licensed Material,” and 49 CFR 172, Subpart I, “Safety and Security Plans.” Specifically, Entergy personnel shipped a radioactive quantity of category 2 Radioactive Material in Quantities of Concern (RAM-QC) on the public highways to a waste processor without adhering to its transportation security plan. Prior to shipment, Entergy staff failed to recognize that the quantity of radioactive material met the definition of RAM-QC. Entergy staff entered this issue into their corrective action program (CAP) as condition report (CR) JAF 2014 02337.

The issue was more than minor because it was associated with the Program and Process attribute of the Public Radiation Safety cornerstone and affected the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain. In accordance with IMC 0609, Appendix D, "Public Radiation Safety Significance Determination Process," the finding was determined to be of very low safety significance (Green) because Entergy had an issue involving transportation of radioactive material, but it did not involve: (1) a radiation limit exceeded; (2) a breach of package during transport; (3) a certificate of compliance issue; (4) a low level burial ground nonconformance; or (5) a failure to make notifications or provide emergency information. This finding had a cross-cutting aspect in the area of Human Performance, Work Processes, in that the documentation (procedures) to support this activity was inadequate [H.7]. (Section 2RS8)

Inspection Report# : 2014003 *(pdf)*

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# Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the cover letters to security inspection reports may be viewed.

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# Miscellaneous

**Significance: N/A** May 03, 2014
Identified By: NRC
Item Type: FIN Finding
**Problem Identification and Resolution**
The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. Entergy personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. Entergy staff appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Entergy typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that, in general, Entergy staff adequately identified, reviewed, and applied relevant industry operating experience to FitzPatrick operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were thorough.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : 2014009 *(pdf)*

**Significance: SL-III** Dec 31, 2011
Identified By: NRC
Item Type: VIO Violation
**EA-10-090/EA-10-248/EA-11-106 RP Technician Willful Violations**
During NRC investigations initiated on July 1, 2009, February 5, 2010, and April 8, 2010, violations of NRC requirements were identified. The following requirements were violated: 10 CFR 20.1703, 'Use of individual respiratory protection equipment'; 10 CFR 20.1501, Subpart F, 'Surveys and Monitoring'; 10 CFR 50.9, 'Completeness and accuracy of information'. Contrary to the listed requirements, the licensee employees willfully violated multiple procedures and incorrectly documented completion of surveys and respirator fit tests.

These violations are categorized collectively as a Severity Level III violation. The NRC offered and Entergy accepted to conduct Alternative Dispute Resolution (ADR) for the above listed violations. The NRC has issued Confirmatory Order (CO) EA-10-090, EA-10-248, EA-11-106 in response to the agreed upon ADR actions. As addressed in the CO, no civil penalty was assessed based on previous actions completed and actions agreed to be completed by the licensee.

Inspection Report# : 2011009 *(pdf)*

Last modified : June 16, 2015