

Turkey Point Triennial Fire Protection Inspection Summary

Inspection Dates: February 5-9, 2001
Report Number: 50-250,251/01-02

Inspectors: R. Schin (Lead); G. Wiseman; P. Fillion; R. Deem, NRC Contractor, BNL;
D. Billings (Partial Trainee); and E. Brown (Partial Trainee)

Scope: Performed IP 71111.05, focusing on four fire areas: 1) Units 3 and 4 cable spreading room; 2) Units 3 and 4 auxiliary building breezeway; 3) Unit 4 reactor control rod drive equipment room; and 4) Unit 3B 4160V switchgear room.

INSPECTION RESULTS:

- No findings.
- The licensee initiated 10 action items (9 CRs and 1 CRN) in response to inspector questions. The NRC inspection team considered at least three of them to be potential minor violations or weaknesses:
 - Two cable penetration seals, located below ground level between important fire areas (the auxiliary building breezeway and the Unit 4 reactor control rod drive equipment room) were not being periodically inspected. They had been designated to be inspected in the past, but had not been looked at because access was not convenient (inspection access apparently involved cutting welds on a steel floor plate in the Unit 4 CRD room, next to the scram breakers.) Licensee QA records indicated that the seals had been installed. Also, licensee inspection of the cable trench on Friday 2/9/01 (by lifting manhole covers in the aux. bldg. breezeway) revealed that the trench was clean and dry and one end of one of the two penetration seals could be seen. The team judged that the licensee's failure to inspect these penetration seals did not have an actual or credible impact on safety.
 - Some of the smoke detectors in the 3B 4160V switchgear room were not located per code requirements (NFPA 72E-1982). The team judged that the incorrectly located smoke detectors did not have an actual or credible impact on safety.
 - The licensee had never tested the cable spreading room halon system or the room integrity and had no design calculations to support its operability. They had a certification from the vendor that the system would fill the room with an adequate halon concentration and that the room would maintain that concentration for an adequate period of time. The quantity of halon bottles and the room integrity looked to the inspectors to probably be sufficient (based on experience). However, current industry practice (not committed to by the licensee) is to test room integrity to assure there is no excessive leakage. The team noted that recent tracer gas testing of control room integrity at numerous plants has shown that in most cases the actual room leakage far exceeds the licensee's estimates. The team judged that the lack of testing or calculations for the cable spreading room halon system did not have an actual or credible impact on safety. Also, the condition may not violate NRC requirements.

SUCCESSSES:

NN/2

- Licensee communication with the team was exceptionally good. Licensee personnel tracked all written team questions in a computerized matrix and ensured that they were providing timely answers. Also, licensee personnel were open and forthright in providing information to the team.

CHALLENGES:

- The licensing manager complained to the SRI and RII management about hours to be billed for this inspection and being billed for trainees. After being informed of this concern by the SRI and RII management, the lead inspector spent about one hour with the licensing manager explaining the inspection procedure hours, approximate hours that had been charged on previous similar NRC fire protection inspections at other sites, differences between the two, differences among NRC regions, differences from past NRC practices, and reasons for billing them for some hours of D. Billings and E. Brown. The licensing manager was very receptive and had no further questions. Apparently he had erroneously underbudgeted significantly for the cost of NRC inspections. We may need to do similar explaining at other sites.
- Some licensee personnel focused on "What is the requirement" instead of "What is the risk." In response to these questions, the lead inspector gave a short presentation on the new inspection process and how it is focused on risk. The presentation was well received by licensee personnel including the Site VP. We may need to do more of this.
- The team struggled with inspecting operator actions. The licensee had no thermal-hydraulic time lines for Appendix R fires and had not done a formal V&V of the Appendix R safe shutdown procedures. However, time lines and V&V were not required and the inspectors could not demonstrate that any operator action times were inadequate. Also, the licensee had removed some Thermo-lag and replaced it with added operator actions, using 50.59 safety evaluations. All of these issues with inspection of operator actions are generic and are being addressed by the ROP fire protection oversight group.
- The AIRTRAN flight to Miami was late and luggage was late, which delayed us by about one and one-half hours, delayed the start of the inspection, and caused us to reschedule the entrance meeting from 1:00 to 3:00 p.m. We need to complain to our Travel Dept. about poor airline service when it occurs.
- The licensee supplied much of the requested reference materials on a CD and supplied the team with two computers to read the CD. The team found that use of the CD involved additional team time to print out items to be reviewed (e.g., procedures). Also, the CD format was not good for reviewing or printing drawings. We need to determine what is the most cost-efficient format for each type of information requested.
- The team relied on shipping boxes of printed reference materials between the site and Atlanta (three times). Problems with delayed licensee shipping of the materials after the onsite inspection week negatively impacted the report writing. We should review what is the best method for transporting printed reference materials.