Turkey Point 4

Initiating Events

Significance: G Mar 31, 2001
Identified By: NRC
Item Type: FIN Finding
Corrective actions for previous Unit 4 loss of offsite power incident not thorough.
Green. Some of the licensee's corrective actions in response to a previous Unit 4 loss of offsite power incident were not thorough. The incident involved a flooded manhole and an electrical cable fault. NRC inspector questioning led to the identification of numerous manhole sump pump and drain deficiencies. The licensee's periodic inspections of the manholes were not adequate to identify water intrusion. Subsequently, it was identified that 55 of 126 manholes contained accumulations of water. The finding was of very low safety significance because the conditions did not have any adverse impact other than slightly increasing the probability of initiating a reactor trip or other event.
Inspection Report# : 2000006*(pdf)*

Mitigating Systems

Significance: G Sep 30, 2000
Identified By: Licensee
Item Type: FIN Finding
The 4B High Head Safety Injection Pump Was Inoperable
Green. The 4B high head safety injection pump became inoperable because of nitrogen gas leakage from the safety injection accumulators into the pump. Corrective actions for previous similar incidents did not prevent this problem. The finding was determined to be of very low safety significance. Although the licensee's corrective actions for previous similar instances of gas intrusion did not prevent this occurrence, the duration and the extent of the condition was limited by the licensee's corrective actions. Technical Specifications allow a single pump to be out of service for 30 days and the 4B pump was inoperable for only a very small fraction of that time. Only one high head safety injection pump from each unit (of the four total pumps) is required for accident mitigation. (Section 1R15)
Inspection Report# : 2000004*(pdf)*

Significance: G Sep 30, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
RHR Room Sump Level Switches Not Included in the Maintenance Rule
Green. A Non-Cited violation of 10 CFR 50.65 (b)(2) was identified because residual heat removal pump room and heat exchanger room sump level alarm switches were not included in the scope of the maintenance rule monitoring program. The switches were not periodically checked and some were not functional when they were subsequently tested. The failure to include the switches in the maintenance rule program was determined to be of very low safety significance. Although the alarm switches could affect the response to an internal flooding incident, the potential impact on accident mitigating systems was limited. The sump pumps located in the rooms that had inoperable level alarm switches were verified to be operable. No credible postulated flooding incidents were identified which could impact both residual heat removal trains simultaneously. (Section 1R06)
Inspection Report# : 2000004*(pdf)*

Significance: G Sep 30, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
Incorrect Design for Valve Position Indication Of Containment Isolation Valves
Green. A Non-Cited violation of 10 CFR 50, Appendix B, Criterion III was identified because the licensee did not correctly implement valve position indication circuitry design requirements on six containment isolation valves. The finding was of very low safety significance because the safety function of the valves was not affected. The condition involved only the valve position indications. The licensee's design control program has changed significantly since the time that this noncompliance occurred. This issue was identified through good questioning by an operator. (Section

4OA3)
Inspection Report# : 2000004*(pdf)*

Significance: G Sep 29, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Control Room Emergency Ventilation System Inoperable
TS 3.7.5 requires that the Control Room Emergency Ventilation System shall be operable. The system was found inoperable during surveillance testing due to failure of a backup emergency supply fan to start as a result of a mispositioned damper effecting the low flow actuation setting. This issue was described in CR 01-1197. (Green)
Inspection Report# : 2001005*(pdf)*

Significance: G Jun 30, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Inadequate Verification of Skills and Training for Personnel Working on Safety Related Motor Operated Valves
10 CFR 50 Appendix B Criteria II, Quality Assurance Program, requires that a program be established to verify the skills and training of personnel performing activities affecting quality. During the Unit 4 refueling outage conducted in October 2000, verification of training was inadequate for personnel conducting work on several safety related motor operated valves. This issue was described in CR 00-2164. (Green)
Inspection Report# : 2001004*(pdf)*

Significance: G Mar 31, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Meet TS Time Requirement for QPTR Calculation
Green. The licensee's review of a recent reactor trip involving two dropped control rods focused on the cause of the trip and did not fully review all aspects of Technical Specification compliance. A Non-cited violation was identified for failure to complete the Quadrant Power Tilt Ratio determination within the time period required in Technical Specification 3.2.4. The safety significance of this finding was very low because, although the time requirements were not met, the power distribution during this period remained within the design values assumed in the Updated Final Safety Analysis Report (Section 1R14).
Inspection Report# : 2000006*(pdf)*

Significance: G Dec 30, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Follow Procedural Requirements During Fuel Movement
TS 6.8.1.a requires that written procedures shall be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33. Refueling and Core Alterations are included in that Appendix. Two examples were identified where a fuel assembly was placed in the wrong spent fuel pool location. On October 2, 2000 and again on October 3, 2000, during de-fueling of the core, personnel incorrectly verified the Spent Fuel Pool location of a fuel assembly and placed the fuel assembly in the wrong location. Both examples were contrary to procedural requirements in 4-OP-040.2, Refueling Core Shuffle. One of the assemblies did not meet the TS 3.9-1 burnup requirements for storage in the location in which it was initially placed. These issues are described in the licensee's corrective action program in CR's 00-1759 and 00-1771.
Inspection Report# : 2000005*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance: 

Dec 30, 2000
Identified By: NRC
Item Type: FIN Finding
Protective Strategy Deficiencies Identified During Drills
Green. During the conduct of table-top drills, the inspectors identified issues with deployment strategies and target set development and concluded that some equipment is not fully protected by the currently established protective strategy. The issue was of very low safety significance because it involved vulnerabilities in safeguards plans identified through table top drills and no actual security incident or threat occurred. (Section 3PP3.4)
Inspection Report# : 2000005*(pdf)*

Miscellaneous

Significance: N/A Mar 30, 2001
Identified By: NRC
Item Type: FIN Finding
Corrective Action Program
The licensee was effective at identifying problems at a low threshold and entering them into the corrective action program. Problems entered into the program were adequately evaluated and appropriate corrective actions were identified. Formal root cause evaluations and corrective actions for significant issues were thorough and detailed. Corrective actions were generally implemented in a timely manner, commensurate with their safety significance. The inspectors identified a few minor problems. Several condition reports did not identify or evaluate all pertinent deficiencies involved with issues, and two minor problems related to corrective actions were identified. Licensee audits and assessments were effective. Operating event information was effectively utilized. Recent problems related to human errors were receiving high levels of licensee management attention. Overall, a safety conscious work environment was present. Discussions with workers and other information indicated that employees were not reluctant to report nuclear safety issues.
Inspection Report# : 2001003*(pdf)*

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