Turkey Point 4

Initiating Events

Mitigating Systems

Significance: G Sep 28, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to take Corrective Action Required by the Maintenance Rule for RHR Sump Pump Failures
Green. The licensee did not correctly assess and take corrective action when the Residual Heat Removal (RHR) sump pumps performance goals were not met. This is a violation of the Maintenance Rule, 10 CFR 50.65. The system had not been placed into status a(1) when multiple failures caused the established performance goals to not be met. This finding was of very low safety significance because it involved administrative implementation of the Maintenance Rule, and the probability of a flooding event that could impact both trains of the RHR system was extremely low. (Section 1R12).
Inspection Report# : 2002003*(pdf)*

Significance: G Aug 23, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Ineffective Corrective Actions To Prevent Recurring Charging Pump and 4KV Breaker Failures
A noncited violation of 10 CFR 50, Appendix B, Criterion XVI was identified for ineffective corrective actions to prevent recurring charging pump and vital electrical breaker functional failures. These failures constituted repetitive significant conditions adverse to quality. This finding was considered more than minor due to the safety significance of the affected systems and because actual loss of component safety functions occurred. The charging pump controller failures, and the failure of the 3A component cooling water pump breaker were determined to be of very low safety significance by the significance determination process because the failures did not reduce the number of available pumps to below that required for each of the involved systems to perform their safety function. (Section 4OA2.c).
Inspection Report# : 2002005*(pdf)*

Significance: N/A Jun 29, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to comply with procedure for taking Operator Rounds
Technical Specification 6.8.1 requires that written procedures shall be established, implemented, and maintained covering the log entry activities in Appendix A of Regulatory Guide (RG) 1.33, Revision 2, February 1978. Procedure 0-OSP-201.4, ANPO Daily Log, requires that a tour of the Auxiliary Feedwater Cage be completed and a specified number of pumps, valves, and governor readings be observed and data recorded. Contrary to the above, on September 27, 2001, a Senior Nuclear Plant Operator, failed to comply with the above requirements when, during his rounds in the Auxiliary Feedwater Cage he spent an inadequate amount of time within the cage to accomplish the required tour. This issue was placed in the licensee's corrective action program as Condition Report 01-1883.
Inspection Report# : 2002002*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance: N/A Mar 30, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Communication of NRC Inspector's Presence and Arrival by Security Supervisor
No Color. A non-cited violation of 10 CFR 50.70 (b) (4) was identified for failure to ensure that the arrival and presence of a NRC inspector was not announced or otherwise communicated. A NRC inspector while in the main truck gate control cubicle overheard, when the telephone was answered using the speaker phone, communication by a security supervisor to a security officer announcing the inspector's presence. This issue is more than a minor because it has the potential for impacting the NRC's ability to perform its regulatory function (Section 3PP2).
Inspection Report# : 2001007*(pdf)*

Miscellaneous

Significance: N/A Aug 23, 2002
Identified By: NRC
Item Type: FIN Finding
Identification and Resolution of Problems
Overall, the licensee's corrective action program (CAP) was effective at prioritizing, evaluating and resolving conditions adverse to quality. The licensee was particularly effective at identifying problems with a low threshold and entering them into the CAP. One finding was identified involving corrective actions that were not fully effective in preventing repetitive failures of charging pumps and important electrical breakers. Several negative observations were also identified during the inspection. Some Condition Report records did not contain documentation to fully support disposition of the issues in that apparent causes or corrective actions were not adequately described. The significance level of some condition reports was not in accordance with licensee program guidance. Also, the Plant Nuclear Safety Review Committee was not consistently reviewing Technical Specification violations documented in NRC inspection reports. Operating experience information, including NRC generic communications, was routinely reviewed for applicability in a timely manner and effectively utilized. Root cause analyses were usually comprehensive and in-depth, and apparent cause determinations were sufficiently rigorous. Overall, audits and self-assessments were sufficiently critical and thorough; licensee identified findings, weaknesses, areas of improvement, or recommendations were consistently tracked to resolution. For almost all problems, appropriate corrective actions were developed and implemented in a timely manner commensurate with the safety significance. A safety conscious work environment was evident at Turkey Point where employees felt free to raise safety concerns.
Inspection Report# : 2002005*(pdf)*

Last modified : March 25, 2003