

## Turkey Point 4

### 2Q/2005 Plant Inspection Findings

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#### Initiating Events

**Significance:**  Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

##### **Failure to implement fire protection procedures**

The inspectors identified a non-cited violation of Technical Specification 6.8.1, Procedures and Programs when the licensee failed to notify control room personnel when a reflash fire was suspected in the Unit 4 main transformer. Section 5.2.2 of the fire protection program requires that individuals discovering a fire which cannot be safely extinguished using the fire fighting equipment close at hand, shall immediately notify the Shift Manager or the appropriate Reactor Operator.

This finding is more than minor because if left uncorrected, a more significant safety concern would arise, that being prompt assessment, classification, notification, and response to a fire within the nuclear complex. The issue was of very low safety significance because (1) the fire zone was outside the vital areas of the plant, and (2) safe shutdown equipment was not affected. The cause of the finding involved the cross-cutting element of Human Performance. (Section 1R14)

Inspection Report# : [2005003\(pdf\)](#)

**Significance:**  Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

##### **Failure to follow procedures to identify and investigate unusual reactor coolant system leakage**

The inspectors identified a non-cited violation of Technical Specification 6.8.1, Procedures, when the licensee failed to follow procedures for identifying and resolving high unidentified reactor coolant system leakage.

This finding was more than minor because any increase in unidentified reactor coolant system leakage could be viewed as a precursor to a significant event, that being failure of the reactor coolant system pressure boundary. The issue was of very low safety significance because when investigated following a second high leakage rate determination, leaking valves in a support system were identified as the cause and no actual reactor coolant system boundary leakage occurred. The cause of the finding involved the cross-cutting element of Human Performance. (Section 1R22)

Inspection Report# : [2005003\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

##### **Failure to identify and report conditions potentially adverse to plant safety involving availability of operators for event response duties when assigned collateral duties**

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B Criterion XVI, Corrective Action, and licensee administrative procedure NAP-204, Condition Reporting when the licensee failed to enter a condition adverse to quality in the corrective action program in that on multiple occasions a plant responder was not available to respond to an event by virtue of being locked out of the plant protected area.

The issue was more than minor because if left uncorrected, it would become a more significant safety concern, that being degradation of the ability of the licensee to respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance because the times the operator was locked out were brief (less than one hour) and safe shutdown equipment was not affected. The Mitigating Systems Cornerstone was affected and the finding was associated with the attributes of Protection Against External Factors (fire). The finding involved the cross-cutting element of Problem identification and Resolution. (1R14)

Inspection Report# : [2005003\(pdf\)](#)

**G****Significance:** Mar 31, 2005

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**Plant Shutdowns Due to Drop of Shutdown Bank B Rod E-11 During Low Power Physics Testing Due to an Inadequate Vendor Procedure**

A Green self-revealing Non-Cited Violation (NCV) of 10 CFR 50, Appendix B, Criterion V was identified for the failure to include adequate instructions in procedures which resulted in two manual reactor trips due to two rod drop events.

This finding was greater than minor because it involved the procedure quality and adequacy attributes of the initiating events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown and power operations. The finding was analyzed using the Significance Determination Process (SDP) Phase 1, and was determined to be of very low safety significance (Green). While the finding resulted in two events where Shutdown Bank B Rod E-11 dropped into the core and subsequent manual reactor trips due to being in a conditions where Technical Specification 3.0.3 was entered, the finding did not result in the likelihood that mitigation equipment or functions would not be available.

Inspection Report# : [2005002\(pdf\)](#)**G****Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**High Head Safety Injection Pump Inoperable Due to an Increase in a Previously Identified Oil Leak**

A self revealing Non-Cited Violation (NCV) of Technical Specification (TS) 3.5.2, Action statement c. occurred as a result of the licensee discovering that one of the four required High Head Safety Injection (HHSI) pumps was inoperable for greater than 30 days, and the unit was not shut down, as required. The pump was discovered to have less than the amount of lube oil needed for it to complete its required safety function and it was determined that this condition had existed for 60 days.

This finding was greater than minor because it involved the equipment performance attribute of the mitigating system cornerstone and affected the objective of ensuring that equipment is available and capable to respond to an event. An SDP Phase 3 was performed by a Regional Senior Reactor Analyst and determined that this finding was of very low safety significance (Green) because one of the remaining three HHSI pumps (two for Unit 3 and one for Unit 4) could perform its safety function. This finding directly involved cross cutting aspects of problem identification and resolution, that being inadequate assessment and initial corrective actions which resulted in the 4B HHSI pump being inoperable from June 6, 2004 until August 5. (Section 4OA3.1)

Inspection Report# : [2004005\(pdf\)](#)**G****Significance:** Oct 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Implement Adequate Test Controls**

The inspectors identified a non-cited violation (NCV) of 10 CFR 50 Appendix B, Criterion XI, Test Controls, for inadequate test controls. These controls were associated with tests developed and implemented for demonstrating that replacement safety-related multiplier/divider cards and peripheral amplifiers manufactured by NUS, were acceptable like-for-like replacement of Hagan components in the analog computer and for time response tests performed by the licensee for the original Hagan square root module and the summator module with 10- and 39-micro farad capacitors. The licensee entered this issue into their corrective action program as 2004-10337-CR, for tracking the development of approved test procedures and completion of response time testing.

This finding is greater than minor because inadequate test controls could result in an inadequate test of equipment in the mitigating system cornerstone and thereby result in improper equipment operation. This could result in plant operation outside of analyzed conditions. Such operation could affect the availability, reliability, and capability of mitigating systems to respond to initiating events and prevent undesirable consequences. This finding is of very low safety significance because it did not result in a loss of system function per Generic Letter 91-18. (Section 4OA2.c(2)(a))

Inspection Report# : [2004011\(pdf\)](#)**G****Significance:** Oct 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Use Adequate I&C Procedures for Refurbishment of Westinghouse Hagan Modules**

An NCV of 10 CFR 50 Appendix B, Criterion V, Instructions, Procedures and Drawings, was identified by the inspectors for the licensee's failure to prescribe by documented instructions or procedures of a type appropriate to the circumstances, activities associated with refurbishment and/or repair of reactor protection system circuit components. Specifically, technicians were using uncontrolled, unreviewed and unapproved checklists, as well as uncontrolled Excel spreadsheets, in order to affect repairs and refurbishment to Hagan modules associated with safety-related functions in the reactor protection system. The licensee entered this issue into their corrective action program as 2004-

10337-CR, for the evaluation, benchmark and drafting of more formal instructions for the conduct of the Hagan Repair Program.

This finding is greater than minor because inadequate procedures which are used to repair and refurbish Hagan modules could result in changes to the performance characteristics of equipment in the mitigating system cornerstone that are less conservative than the original equipment manufacturer's (OEMs) specifications. Such changes, e.g., time response, could result in plant operation outside of analyzed conditions and could affect the availability, reliability, and capability of mitigating systems to respond to initiating events, and prevent undesirable consequences. This finding is of very low safety significance because it did not result in a loss of system function per Generic Letter 91-18. (Section 40A2.c(2)(b))

Inspection Report# : [2004011\(pdf\)](#)

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**Significance:** Oct 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Establish Adequate Interim Corrective Action to Preclude Use of Unqualified Capacitor**

An NCV of 10CFR50 Appendix B, Criterion XVI, Corrective Action, was identified by the inspectors for the licensee's failure to take adequate corrective action to preclude the use of an inadequately evaluated alternate replacement capacitor. This issue was entered into the licensee's corrective action program as 2004-10324-CR, to revise the Instock Disposition Status of Passport Evaluation 080201, Stock Code 0003546-2, to ensure that the capacitor cannot be used for Hagan modules.

This finding is greater than minor because the licensee's actions to preclude the use of an unqualified capacitor in safety-related applications were not sufficient to prevent an I&C technician from requesting it from the stores. The part was listed as acceptable for use in the vendor technical manual, and was available from stores. The use of this unqualified capacitor in equipment in the mitigating system cornerstone could result in changes to equipment performance characteristics, and result in plant performance outside of analyzed conditions. Such operation could affect the availability, reliability, and capability of mitigating systems to respond to initiating events and prevent undesirable consequences. This finding is of very low safety significance because it did not result in a loss of system function per Generic Letter 91-18. (Section 40A2.c(2)(c))

Inspection Report# : [2004011\(pdf\)](#)

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**Significance:** Sep 25, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Corrective Action for Scaffold Construction Deficiencies**

A Green NCV was identified for failing to implement adequate corrective actions per 10 CFR 50, Appendix B, Criterion XVI, for issues related to the construction of scaffolding in proximity to safety related equipment or fire protection components.

This finding is more than minor because it affected the Mitigating Systems cornerstone. Improper construction of scaffolding, and lack of engineering review of scaffolding not built in accordance with the procedure, could prevent proper operation of fire protection features, limit or prevent access to components required of emergency response, or render equipment inoperable as a result of a seismic event. This finding is of very low safety significance because it did not result in an actual loss of safety function and would not render equipment inoperable due to seismic events. The finding is related to the cross-cutting element of problem identification and resolution, that being ineffective and untimely corrective actions. (Section 40A2.2)

Inspection Report# : [2004004\(pdf\)](#)

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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

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### Physical Protection

[Physical Protection](#) information not publicly available.

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### Miscellaneous

Last modified : August 24, 2005