

Turkey Point 4 2Q/2016 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 29, 2016
Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Correct Conditions Adverse to Quality Associated with the Eagle 21 System

Green. NRC reactor inspectors identified Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” for a failure to correct a condition adverse to quality. The licensee identified that the ability to test the Eagle 21 was degraded but failed to take adequate corrective actions to correct the condition. The licensee entered the issue into their corrective action program as action request ARs 2023314 and 02145155.

The performance deficiency was determined to be more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, not using COLR specified time-constants SR tests to demonstrate operability of the Eagle 21 system adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of the OP?T and OT?T reactor trip algorithms. The finding was determined to be of very low safety significance (Green) because of the defense in depth of the reactor protection system to cause a trip via alternate and diverse means. The inspectors determined the finding was indicative of present licensee performance and was associated with the cross-cutting aspect of human performance, in the area conservative bias, because individuals failed to evaluate a proposed action to determine if it was safe in order to proceed, rather than unsafe in order to stop (H14).

Inspection Report# : [2016002](#) (*pdf*)

Barrier Integrity

Significance:  Dec 31, 2015
Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to correctly follow procedure 3 PMI 072.6, “Steam Dump to Atmosphere Control Loop Calibration.”

A self-revealing NCV of Technical Specification (TS) 6.8.1, “Procedures and Programs,” was identified when the licensee failed to properly implement procedure 3 PMI-072.6, “Steam Dump to Atmosphere Control Loop Calibration.” Specifically, the licensee incorrectly installed a temporary electrical jumper in reactor operator console 3C02 instead of 3C04, in contrast to Step 6.3.2 of 3-PMI-072.6. This action resulted in actuation of a 3B 4160 volt (V) vital bus lockout circuit causing loss of power to the B train of Unit 3 (U3) spent fuel pool (SFP) cooling. Immediate

corrective actions were taken to remove the jumper and restore the B train of SFP cooling. The licensee entered the condition in its corrective action program (CAP) as action request (AR) 02088911 and 02088914.

The performance deficiency was determined to be more than minor because it was associated with the human performance attribute of the barrier integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system (RCS), and containment) protect the public from radionuclide releases. In addition, the performance deficiency, if left uncorrected, had the potential to lead to a more significant safety concern. The finding was screened using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," Tables 2 and 3, dated July 1, 2012, and Appendix G Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Initial Screening and Characterization of Findings," Exhibit 4 for Barrier Integrity, dated May 9, 2014. The inspectors determined the finding was of very low safety significance (Green) because it was not associated with low temperature over pressurization, freeze seals, steam generator nozzle dams, criticality, drain down or leakage paths, or the containment barrier. Furthermore, one train of SFP cooling remained in operation, the rate of SFP temperature rise was low (~ 2 °F/hour), and additional methods remained available to limit SFP temperature rise. This finding was assigned a cross cutting aspect associated with the procedure adherence element of the human performance area because the licensee failed to correctly execute step 6.3.2 of procedure 3-PMI-072.6 (H.8). (Section 1R20)

Inspection Report# : [2015004](#) (pdf)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 29, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Post a High Radiation Area

Green. A self-revealing, Green, NCV of TS 6.12.1, was identified by health physicist inspectors for the failure to post a high radiation area (HRA). Specifically, on April 6, 2016, the licensee failed to post the area by the exterior wall of the U4 spent fuel pool (SFP) on the Auxiliary Building roof as a HRA.

This finding was determined to be greater than minor because it was associated with the Occupational Radiation Safety Cornerstone attribute of Human Performance and adversely affected the cornerstone objective ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Specifically, failure to post and control HRAs can allow workers to enter HRAs without knowledge of the radiological conditions in the area and receive unintended occupational exposure. The finding was evaluated using the Occupational Radiation Safety Significance Determination Process. The finding was not related to the As Low As Reasonably Achievable (ALARA) planning, did not involve an overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. Therefore, the inspectors determined the finding to be of very low safety significance (Green). This finding involved the cross-cutting aspect of Human Performance, Work Management (H.7) because the organization failed to implement its process for planning and controlling access to HRAs on the Auxiliary Building roof when fuel bundle movement were still ongoing. The violation was entered into the licensee's corrective action program (CAP) as action request (AR) no. 02123851.

Inspection Report# : [2016002](#) (pdf)

Public Radiation Safety

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.

Miscellaneous

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