

Turkey Point 3

4Q/2008 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2008

Identified By: Self-Revealing

Item Type: FIN Finding

Maintenance causes smoke and fumes to enter the control room causing fire alarms.

A Self-Revealing finding of very low safety significance was identified after smoke and welding fumes from maintenance entered the control room through the ventilation system causing smoke alarms. When identified, the licensee stopped the maintenance and entered the issue into the corrective action program as CR 2008-17166.

The Initiating Events cornerstone was affected when smoke alarms occurred requiring the operators to initiate actions to protect themselves and the plant. The event screened as Green when mitigating systems remained unaffected and would have functioned, if needed. The cause of the finding is related to the cross-cutting area of Human Performance, Work Practices, (H.4.b) when personnel did not follow procedures in developing the work package for metalizing operations outside of the control room. (1R05)

Inspection Report# : [2008003](#) (*pdf*)

Mitigating Systems

Significance:  Nov 17, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Verification Affecting AFW Flow Control Valves and Unit 3 EDG Building Room Ventilation

The team identified a finding of very low safety significance involving two examples of a non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion III, Design Control. Specifically, in one example, the licensee failed to establish design control measures to verify or check the adequacy of critical design inputs for the calculation that determined that the Unit 3A and 3B emergency diesel generators (EDGs) would be operable at outside ambient temperatures at or below 75°F if the 3A and 3B Diesel Building Ventilation Fans are out of service as allowed by procedures. In the second example, the licensee failed to ensure the adequacy of design for the auxiliary feed water steam generator flow control valves.

The finding was more than minor because it was associated with the Design Control attribute of the Mitigating System Cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team assessed the finding using the SDP and determined that the finding was of very low safety significance (Green) since it was a design deficiency determined not to have resulted in the loss of safety function. Specifically, in both cases, the licensee had not operated in a condition for which the design deficiencies in question were relied upon for operation. Both examples had been entered in the licensee's corrective action system. The finding was evaluated for cross-cutting aspects and none were identified. (Sections 1R21.2.3 and 1R21.2.4)

Inspection Report# : [2008006](#) (*pdf*)

G**Significance:** Nov 17, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Verify Limiting Value Adequacy for Safety-Related Battery Intercell Resistance

The team identified a NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance involving the failure to verify and ensure that the 125 VDC safety-related batteries would remain operable if all the inter-cell and terminal connections were at the resistance value (< 150 micro-ohms) allowed by technical specification (TS) surveillance requirement (SR) 4.8.2.1.b(2)/c(3) and maintenance procedure 0-SME-003.3/.4/.15.

The finding was more than minor because if left uncorrected, the finding would become a more significant safety concern. Specifically, the 125 VDC safety-related batteries would become incapable of meeting their design basis function if the inter-cell and connection resistance were allowed to increase to the TS allowed value. The finding was of very low safety significance since it was a design deficiency determined not to have resulted in the loss of safety function. No cross cutting aspect was identified for this finding. The licensee entered this deficiency into their corrective action program. (Section 1R21.2.16)

Inspection Report# : [2008006](#) (*pdf*)**G****Significance:** Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to implement procedures that assure component lineups prior to power escalation.

The inspectors identified a non-cited violation of Technical Specification (TS) 6.8.1, Procedures for failure to implement Unit 4 plant startup requirements regarding alignment of components that support operability of the recirculation sump. When identified, the licensee corrected the alignments and entered the issues into the corrective actions program as CR 2008-15444 and 2008-15505.

The Mitigating Systems cornerstone was affected when standby equipment was not in the specified ready lineup. The finding screened to be of very low safety significance when no loss of safety function occurred. The cross-cutting area of Human performance – Work Practices (H.4.c) was affected when the licensee did not assure supervisory oversight of work activities (valve lineup and debris gate position) to assure that nuclear safety was supported. (1R20)

Inspection Report# : [2008003](#) (*pdf*)**G****Significance:** Jun 30, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to take timely corrective actions leads to emergency diesel generator failure.

A Self-revealing Non-cited violation of 10 CFR 50, Appendix B, Criterion XVI was identified when external corrosion of a Unit 3 emergency diesel radiator was not promptly repaired resulting in a diesel failure. The licensee repaired the radiator and entered the event into their corrective action program as CR 2008-11134.

The finding affected the equipment performance attribute of the Mitigating System cornerstone due to the impact on availability and reliability of the EDG system. The finding screened to be of very low safety significance, Green, when the loss of safety function for the single train did not exceed the allowed outage time. The finding involved the cross-cutting area of Problem Identification, and Resolution, (P.1.c), when the licensee did not thoroughly evaluate the radiator corrosion such that the issue could be resolved prior to failure. (4OA2)

Inspection Report# : [2008003](#) (*pdf*)

G**Significance:** Mar 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to implement procedures regarding overtime hours for plant operations personnel

The inspectors identified a Non-cited violation of Technical Specification (TS) 6.8.5 for the failure of the licensee to properly implement procedure requirements regarding the control of overtime for operations personnel that may perform safety-related duties. To address this issue the licensee has revised the operations shift scheduling to reduce or eliminate the need for overtime beyond the limits specified in licensee procedures.

The finding is greater than minor in accordance with Inspection Manual Chapter (IMC) 0612, Power Reactor Inspection Reports, "Appendix B, Issue Screening." If left uncorrected, the excessive work hours could adversely affect the station's defense-in-depth and increase the likelihood of human errors during response to plant events and would become a more significant safety concern. The failure to implement requirements for controlling the use of overtime is contrary to TS and is a performance deficiency which could adversely the impact operability to monitor safe operation of the plant and other onsite activities. This issue has a cross-cutting aspect in the area of Human Performance, Resources (Item H.2.(b) of IMC 0305, because sufficient qualified personnel were not available to maintain working hours within working hour guidelines.

Inspection Report# : [2008002](#) (*pdf*)**G****Significance:** Sep 30, 2007

Identified By: NRC

Item Type: FIN Finding

Recurring Problems with Alternate Shutdown Communication Equipment

The inspectors identified a finding when the licensee did not identify and correct an adverse trend of recurring problems with the alternate shutdown communications system. When identified, the licensee entered the issue into the corrective actions program and initiated a review of reliability issues with the communications equipment.

The finding is more than minor because it affects the availability and reliability of the communications system used by plant operators to mitigate certain fire scenarios. The issue was of very low safety significance because an alternate communications system (radios) was available, if needed. The cause was related to the cross-cutting area of problem identification and resolution because the adverse trend of problems with alternate shutdown communications had not been identified nor corrected by the licensee commensurate with its safety significance. (IMC 305, P.1 (d)) (4OA2)

Inspection Report# : [2007004](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: SL-IV Dec 31, 2008

Identified By: NRC

Item Type: VIO Violation

Failure to Accomplish An Activity Affecting Quality in Accordance with Procedures

Inspection Report# : [2008005](#) (*pdf*)

Significance: N/A Jun 27, 2008

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The team concluded that in general, problems were properly identified, evaluated, prioritized, and corrected within the licensee's corrective action program (CAP). Evaluation of issues was generally comprehensive and technically adequate. Formal root cause evaluations for issues classified as significant adverse conditions were comprehensive and detailed. The team reviewed the licensee's corrective action program improvement plan and actions to address evaluation quality, timeliness, and overall CAP effectiveness. The team determined that progress has been made in improving all areas addressed by the improvement plan. Overall, corrective actions developed and implemented for issues were effective in correcting the problems. However, the team identified examples where corrective actions have not been entirely effective, or potential adverse trends had not been identified and entered into the CAP.

The team determined that thresholds for identifying issues were appropriately low. Nuclear Assessment Section audits and departmental self-assessments were effective in identifying issues and directing attention to areas that needed improvement. Licensee identified weaknesses and issues in self-assessments were appropriately entered into the CAP and addressed.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors did not identify any reluctance to report safety concerns.

Inspection Report# : [2008008](#) (*pdf*)

Significance: N/A Mar 21, 2008

Identified By: NRC

Item Type: FIN Finding

PI&R Inspection

The licensee was generally effective at identifying problems and initiating condition reports (CR) as required by program procedures. The inspectors determined that the licensee utilized their corrective action program to evaluate, assign corrective actions, and identify adverse trends, including low level issues. The inspectors reviewed the licensee's corrective action program improvement plan and actions to address evaluation quality, timeliness, and overall corrective action program (CAP) effectiveness. In general, the inspectors found the evaluations to be adequate with notable reductions in the CR backlog and evaluation timeliness since the last problem identification and resolution (PI&R) inspection completed in December 2007. The inspectors identified some minor deficiencies associated with corrective actions to prevent recurrence (CAPR) put in place to address the substantive PI&R cross-cutting issue, first identified in 2006 but overall, corrective actions were effective.

On the basis of interviews conducted during the inspection, a review of the Employee Concerns Program, and the

results of the licensee's safety conscious work environment (SCWE) surveys, the inspectors determined that employees felt free to raise concerns without fear of retaliation.

Inspection Report# : [2008007](#) (*pdf*)

Last modified : April 07, 2009