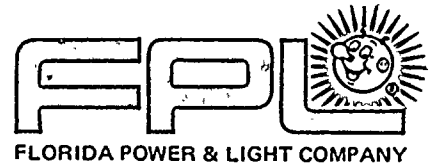


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L-86-211

Dr. J. Nelson Grace
Regional Administrator, Region II
U. S. Nuclear Regulatory Commission
101 Marietta Street N.W., Suite 2900
Atlanta, Georgia 30303


Dear Dr. Grace:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Inspection Report 250-86-10 & 251-86-10

Florida Power and Light Company has reviewed the subject inspection report and a response is attached.

There is no proprietary information in the report.

Very truly yours,


C. O. Woody
Group Vice President
Nuclear Energy Department

COW/JA/ms/
Attachment

cc: Harold F. Reis, Esquire

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IEO
PEOPLE...SERVING PEOPLE

ATTACHMENT

Re: Turkey Point Units 3 and 4
Docket No. 50-250, 50-251
IE Inspection Report 250-86-10 & 251-86-10

FINDING:

Technical Specification (TS) 6.8.1 requires that written procedures and administrative policies be established, implemented and maintained that meet or exceed the requirements and recommendations of sections 5.1 and 5.3 of ANSI N18.7-1972 and Appendix A of USNRC Regulatory Guide 1.33.

FINDING A:

Appendix A of USNRC Regulatory Guide 1.33 states that written procedures should be established for the shutdown cooling system and the emergency core cooling system.

The intake cooling water (ICW) system is an essential subsystem of the shutdown cooling system and the emergency core cooling system.

Operating Procedure 3400.1, Intake Cooling Water System - Normal Operation, provides instructions for ICW system operation and alignment.

Florida Power and Light (FPL) inter-office correspondence PTN-TECH-85-754, ICW Pump Discharge Check Valves, dated November 7, 1985, states that instrument air to the ICW system pump discharge check valve closing cylinders is necessary for continued operation of the ICW system.

FPL inter-office correspondence JPE-PTPM-85-1409, dated December 16, 1985, postulates that the check valve air closing cylinders enhance valve operation by overcoming minor rust/friction binding to reduce check valve slam. The document states that air closing cylinders are not considered essential to ICW system operability provided that operation without instrument air available is kept negligibly short.

Contrary to the above, as of March 10, 1986, Operating Procedure 3400.1, dated August 7, 1985, was inadequate, in that it failed to provide any guidance in the form of requirements and limitations for the operation of the Units 3 and 4 ICW pump discharge check valves (3/4-311, 321, 331) with respect to the availability of instrument air to the check valve closing cylinders.



RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the finding was that Instrument Air to ICW check valves are aligned in OP-013 Instrument Air System, however, this information was not reflected in OP-3400.1, Intake Cooling Water. To better enhance our Operating Procedures, OP 3400.1 will be updated to include instrument air to check valves.
- 3) OP 3400.1, Intake Cooling Water System, will be updated to include Unit 3 & 4 ICW pump discharge check valves with respect to the availability of instrument air to the check valve closing cylinder.
- 4) FPL is currently undergoing a systematic review of Safety Related Systems to identify potential problems and ensure corrective action is taken promptly. This review has been the subject of discussions with Region II staff.
- 5) Full compliance for Item 3 above will be achieved by May 30, 1986.

FINDING B:

Section 5.1 of ANSI N18.7-1972 requires that written administrative policies shall be provided to control the issuance of documents, including changes, that prescribe activities affecting safety-related structures, systems, or components, such as operating procedures, test procedures, equipment control procedures, and refueling procedures. These policies shall assure that documents, including revisions or changes, are reviewed for adequacy and approved for release by authorized personnel and are distributed to and used by the personnel performing the prescribed activity.

Turkey Point Units 3 and 4 Administrative Procedure (AP) 0140.2, Changing Setpoints, dated April 13, 1984, states that the Instrumentation and Control Department is responsible for updating the Precautions, Limitations and Setpoints (PLS) Document and ensuring that Document Control is notified of the approved setpoint modification so that the controlled copies of the PLS Document can be updated.

Contrary to the above, in December 1984, AP 0140.2 was not properly implemented in that the Unit 3 turbine governor runback motor was replaced with a slower speed motor and the associated time delay relay setpoint was increased from 9 to 11.5 seconds, but the PLS Document was never updated to reflect the modified setpoint.



RESPONSE:

- 1) FPL concurs with the finding.
- 2) The documentation for the setpoint change did not identify the PLS document as a document requiring update.
- 3) The PLS has been updated to reflect the setpoint change.
- 4) AP 0140.2 will be revised to be sure the PLS document is not overlooked in the list of affected documents.
- 5) Full compliance for Item 4 above will be achieved by June 30, 1986.

FINDING C:

Section 5.1.6.1 of ANSI N18.7-1972 requires that maintenance which can affect the performance of safety-related equipment shall be properly preplanned and performed in accordance with written procedures, documented instructions or drawings appropriate to the circumstances.

Contrary to the above, on February 11, 1986, maintenance troubleshooting was performed which was not properly preplanned and relied upon a procedure which was not appropriate to the circumstances, in that Off-Normal Operating Procedure 9608.1, dated October 16, 1985, entitled 125 Volt DC System - Location of Grounds, was used for a purpose other than that for which it was intended. Consequently, Operations personnel inadvertently initiated a reactor trip by implementing a procedural step, normally acceptable during ground isolation proceedings, solely to identify the source of a fuse failure in the reactor protection system. The step was inappropriate to the circumstances because no 125 volt DC ground existed and a reactor protection system fault existed which invalidated the procedure guidance.

RESPONSE:

- 1) FPL concurs with the finding in that a procedure not appropriate to the circumstances was used, however, at the time of the incident troubleshooting by the Maintenance Department had not begun. Operations personnel were attempting to locate the source of the problem prior to initiating the Plant Work Order (PWO) to correct the problem.
- 2) An investigation into the cause of the event has revealed two contributing factors:
 - 1) A protection shield had been removed from the areas of several breakers on Unit 4 to facilitate construction activities. This allowed breaker 4D01-39 to be inadvertently opened while construction activities progressed. This occurred because of the belief that work in this area had no effect on Unit 3. Breaker 4D01-39 feeds 3QR51 so when it was opened, one channel of containment high pressure protection annunciated.

- 2) The other factor was that the procedural guidance available to the operator did not provide adequate instructions for investigating this event. This allowed the operator to cycle breaker 3D23-11 before checking the status of the other breakers that feed 3QR51. When 3D23-11 was cycled, the second channel of containment high pressure protection was actuated which resulted in the SI actuation and reactor trip.
- 3) The following corrective actions were taken:
 - a) An on-the-spot change (OTSC) was written for ONOP 0208.10 to remove the operator action of replacing the breaker fuses if the breaker is okay. This could have resulted in a safety injection actuation also.
 - b) Caution tags have been placed at the 125 volt DC busses instructing personnel to ensure that prior to cycling a 125 volt DC breaker, verify that the other panels associated breakers are in a normal configuration.
 - c) ONOP 9608.1 has been revised to add the caution information described in item 3.a above.
 - d) A meeting was held with the Plant Manager - Nuclear, Site Project Manager, and the area/room coordinator for construction activities. This meeting developed the following criteria for construction activities in critical areas:
 - Any work in these critical areas will be coordinated with the area/room coordinators prior to commencing any work activity.
 - These areas will be restricted to personnel that only have a reason to be there.
- 4) Temporary tags have been placed on the safeguards racks to identify the power supply breakers. These tags will be replaced by permanent tags when they are received.
- 5) Full compliance for Item 3 above was achieved by April 1, 1986.