

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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 FACIL: 50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
 AUTH. NAME AUTHOR AFFILIATION
 WOODY, C. O. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to violations noted in Insp Repts 50-250/87-35 &
 50-251/87-03. Corrective actions: Procedure 3/4 OP-041.8 will
 be changed to require partial filling of accumulators prior
 to establishing RCS integrity.

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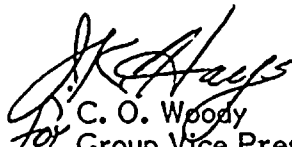
Gentlemen:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Inspection Report 87-35

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

There is no proprietary information in the report.

Very truly yours,


for C. O. Woody
Group Vice President
Nuclear Energy Department

COW/SDF/gp

Attachment

cc: Dr. J. Nelson Grace, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

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ATTACHMENT

RE: TURKEY POINT UNITS 3 AND 4
DOCKET NO. 50-250, 50-251
IE INSPECTION REPORT 250-87-35 & 251-87-35

FINDING A:

Technical Specification 4.1, Operational Safety Review, requires that equipment and sampling tests shall be conducted as specified in Table 4.1-2. Item 10 of Table 4.1-2 requires that accumulator boron concentration be sampled prior to heatup above 200 degrees F.

Contrary to the above, on June 26, 1987, the unit 4 primary coolant system was heated above 200 degrees F without prior performance of the boron concentration analysis for the 4C accumulator.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the finding is that the accumulators were not filled prior to establishing Reactor Coolant System (RCS) integrity. Technical Specification (TS) table 4.1-2 requires boron analysis of the accumulators prior to going above 200 degrees F. However, TS 3.15 does not allow opening of MOV-4-869 whenever the RCS is below 380 degrees F and the RCS pressure boundary is established. MOV-4-869 is the isolation valve for filling the accumulators from the safety injection pumps. This configuration precludes filling the accumulators between establishing RCS pressure boundary and 380 degrees F, thereby leading to this violation.
- 3) The accumulators were filled once the RCS temperature was above 380 degrees F but below 1000 PSI. The boron concentration was verified to be within specification.
- 4)
 - a) Procedure 3/4 OP-041.8, Filling and Venting the Reactor Coolant System, will be changed to require the partial filling of the accumulators prior to establishing RCS integrity and having the chemistry department verify boron concentration in the accumulators to be within specification.
 - b) Chemistry Procedure NC-8A, Primary Chemistry Surveillance during Reactor Startup Mode 6 or 5 through Mode 1, will be changed to include the sampling and analysis of the accumulators for boron concentration before establishing RCS integrity.
 - c) A Technical Specification change will be submitted to align more closely with the Standard TS thus deleting these conflicting requirements.

- 5) a) Full compliance for 3 above was achieved on June 28, 1987.
- b) Full compliance for 4a above will be achieved on December 13, 1987.
- c) Full compliance for 4b above will be achieved by December 13, 1987.
- d) Full compliance for 4c above will be achieved by December 11, 1987.

FINDING B1:

Technical Specification 6.8.1 requires that written procedures and administrative policies shall be established, implemented and maintained that meet or exceed the requirements and recommendations of Appendix A of USNRC Regulatory Guide 1.33.

Regulatory Guide 1.33, Appendix A Item 1.c specifies that written procedures should be developed to control equipment through locking and tagging.

Administrative Procedure 0-ADM-205, entitled Administrative Control of Valves, Locks, and Switches, revision dated July 18, 1987, requires, in Attachment 5 that valve 3-40-856 be locked.

Contrary to the above, on August 6, 1987, Valve 3-40-856 was found not to be locked.

RESPONSE:

- 1) FPL concurs with this finding.
- 2) The reason for this finding is that the last person to lock the valve did not properly secure the handwheel. The valve could still be manipulated despite the installed locking device.
- 3) The handwheel was promptly secured with the locking device as required to prevent manipulation of the valve.
- 4) A training brief was written to emphasize the necessity to properly secure the locking devices to valves in a position to preclude unauthorized valve manipulation.
- 5) a) Full compliance with item 3 was achieved on September 26, 1987.
b) Full compliance with item 4 was achieved by October 6, 1987.

FINDING B2:

Technical Specifications 6.8.1 requires that written procedures and administrative policies shall be established, implemented and maintained that meet or exceed the requirements and recommendations of Appendix A of USNRC Regulatory Guide 1.33.

Regulatory Guide 1.33, Appendix A, Item 6.v specifies that procedures should be developed for combating emergencies and other significant events such as plant fires.

Administrative Procedure 15500, entitled Fire Protection Program, revision dated July 9, 1987, section 9.4.1 requires in part that backup suppression be established as compensatory action during fire protection impairment of automatic fire suppression systems such as the halon system. Section 9.5.3 specifies, in part, that the posting of a continuous firewatch is an acceptable compensatory action when the halon system is impaired. Temporary Procedure 347, entitled DC Equipment and Invertor Rooms Supplemental Cooling Monitoring and Standby Condition, revision dated June 25, 1987, section 5.1.1, requires that any time door 108A-1 is maintained open, a continuous firewatch shall be established to close the door (108A-1) within 60 seconds of the sounding of the Halon Activation Alarm.

Contrary to the above, on July 29, 1987, the continuous fire watch posted at fire door 108A-1 to compensate for an impaired halon system was asleep. Consequently, the effectiveness of the halon system might not have been re-established (through door closure) within the required 60 second time interval.

SPONSE:

- 1) FPL concurs with this finding.
- 2) The reason for this finding was a cognitive personnel error on the part of the firewatch stander. In the interview after the incident, the watch stander indicated that he understood his post requirements included staying alert, but had failed to execute them. The firewatch post at this door is independently inspected every 20 minutes by the roving firewatch. Additional random inspections of this post are performed at least 4 times during each 12 hour shift and the watchstander for this fire door is relieved every 2 hours. A random inspection of this post had last been performed between 1850 and 1900. The sleeping fire watch had been discovered at 1908 by licensee personnel.
- 3)
 - a) The sleeping firewatch stander was replaced with another qualified firewatch stander and the employment of the sleeping firewatch stander was discontinued.
 - b) Firewatch personnel were addressed on the expectations and accountabilities of the fire watch and this orientation has been incorporated into the in house firewatch training.
- 4)
 - a) The supervision of the fire watches has been transferred from the construction department to the fire protection group. As part of the fire protection group, the firewatch standers will report to the group that has the primary responsibility for fire protection.

b) Administrative procedures 0-ADM-13 and 0-ADM-13.4 will be revised to consolidate and revise some of the firewatch standing requirements.

- 5) a) Full compliance with item 3a was achieved on July 29, 1987.
- b) Full compliance with item 3b was achieved on September 14, 1987.
- c) Full compliance with item 4a was achieved on on September 8, 1987.
- d) Full compliance with item 4b will be achieved on December 31, 1987.

FINDING C:

TS 3.7.2.b states that in part that power operation may continue if one diesel generator is out of service provided the remaining is tested daily and its associated engineered safety features are operable.

Contrary to the above, the licensee failed to comply with the requirements of TS 3.7.2.b, in that on July 30-31, 1987, the A EDG was out of service for greater than 24 hours (26 hrs., 50 min.) without verifying the operability of the B EDG.

RESPONSE:

FPL concurs with this finding.

- 2) The reason for this finding is that the work on the out of service EDG had been anticipated to be completed in less than the 24 hour time limit. When it was determined that the out of service diesel generator would not be back in service within the required time frame, adequate time did not exist to complete the operability test on the remaining diesel within the 24 hour period.
- 3) A clarification letter was issued to provide guidance to the operators concerning testing the opposite diesel generators when an diesel generator is out of service. This letter provided the recommendation to test the opposite diesel generator prior to taking a diesel out of service. An on the spot change was than written to operating procedure (OP) 4304.5, Engineered Safety Features (ESF) Equipment Operability Verification with an Emergency Diesel Generator Inoperable, to incorporate this recommendation.
- 4) a) A permanent change was issued to OP 4304.5 to incorporate the on the spot change discussed in item 3.
- b) Plaques will be placed in the control room and in the diesel generator rooms that will remind the operators of this surveillance requirement.
- 5) a) Full compliance with item 3 was achieved on August 11, 1987.
- b) Full compliance with item 4a will be achieved by September 10, 1987.
- c) Full compliance with item 4b will be achieved by November 15, 1987.

