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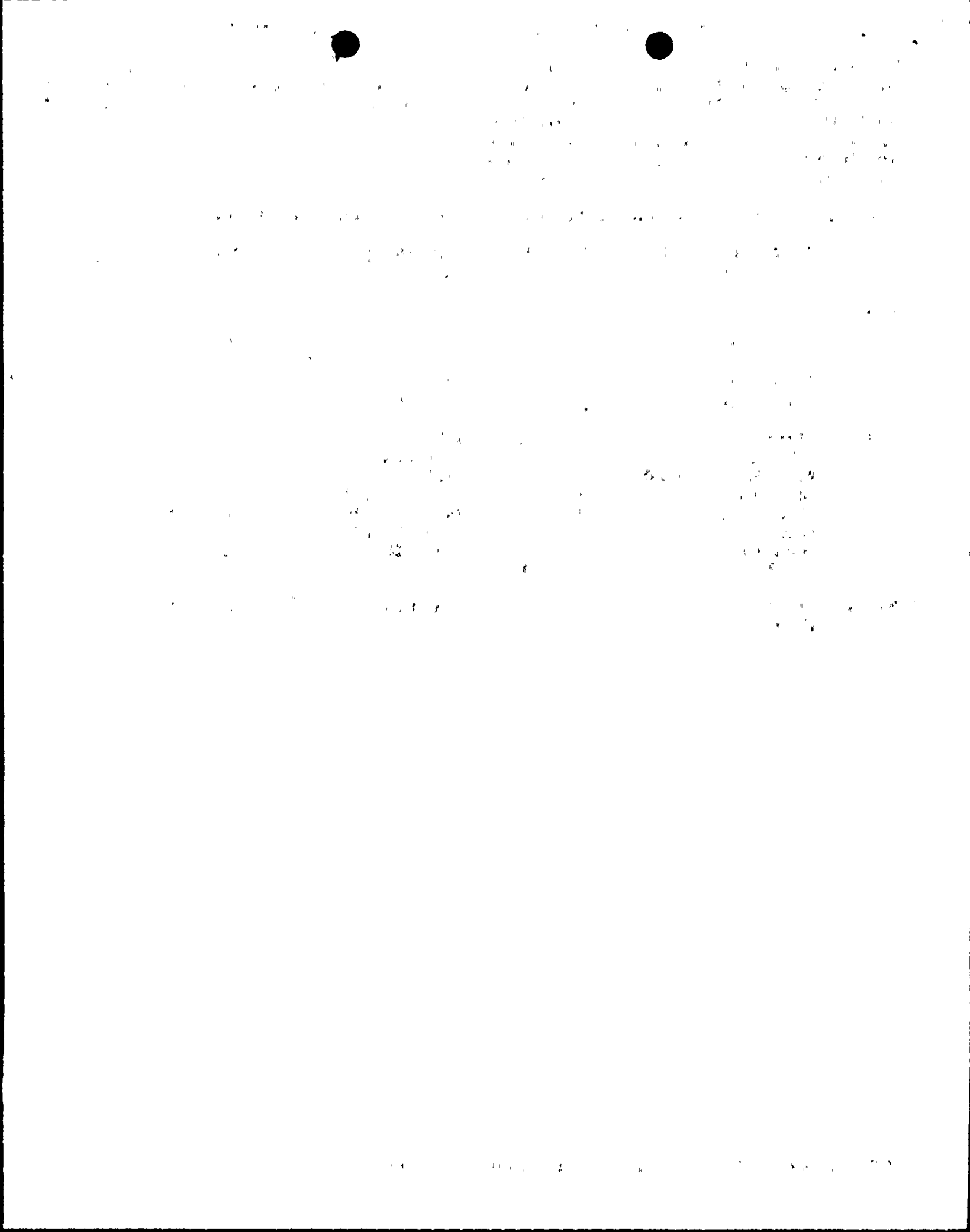
ACCESSION NBR: 8712280273 DOC. DATE: 87/12/16 NOTARIZED: NO DOCKET #
 FACIL: 50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
 AUTH. NAME AUTHOR AFFILIATION
 WOODY, C. O. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION
 GRACE, J. N. Region 2, Ofc of the Director

SUBJECT: Forwards mgt-on-shift weekly repts, per NRC 871019 order.

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DECEMBER 16 1987

L-87-522

87 DEC 18 A10:45

Dr. J. Nelson Grace
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta Street, N.W., Suite 2900
Atlanta, Georgia 30323


Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Management-on-Shift Weekly Report

Dear Dr. Grace:

Pursuant to the Nuclear Regulatory Commission Order dated October 19, 1987, the attached summary of Management-on-Shift (MOS) reports is submitted.

Should there be any questions on this information, please contact us.

Very truly yours,


C. O. Woody
Executive Vice President

COW/SDF/cn
Attachment

cc: J. Lieberman, Director, Office of Enforcement, USNRC
D. G. McDonald, Project Manager, NRR, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant
R. E. Tallon, President, FPL

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MANAGEMENT ON SHIFT (MOS)

WEEK STARTING: December 7, 1987

WEEKLY SUMMARY REPORT

PAGE 1 OF 2

Four MOS observers were on shift: K.J. Wiecek, St. Lucie Plant (12/07-14, 1987, Day); William Detwiler, Westinghouse Electric Corporation (12/07-14, 1987, Night); L.L. Thomas, PTN Outage Manager (12/07-14, 1987, Night); Jim Reed, Training Department MOS Instructor (12/12-14, 1987, Night). While on shift these MOS observers reported any potential safety problems, questionable work practices, operating strengths, areas for improvements, and general recommendations.

During this period, Unit 3 was in Mode 5 and Unit 4 in Mode 1. No items of immediate safety significance were noted. The following questionable work practices were identified:

- Placing paper over the freshly cleaned control room carpet created a potential fire and tripping hazard. Other means to protect the cleaned carpet while it dries are being explored.
- A heater drain pump was tripped while performing maintenance on the heater drain tank level instrumentation.
- The brakes failed on a parked forklift causing it to crash through an RCA gate.

The areas observed that need improvement are listed as follows:

- Logging the completion of system walkdowns.
- The Process Radiation Monitoring Operability Test Procedure unnecessarily cycles an air supply valve during a Decay Tank Gas Release.
- An Electrical Maintenance Procedure concerning Battery Electrolyte levels and the Turbine Operator's log do not provide a minimum specification for low level condition. An administrative limit for these documents was recommended to ensure that the Interim Technical Specification requirements are satisfied. A similar problem was noted on November 29, 1987. Corrective actions are in progress.
- Deviations from written procedure steps are allowed under strict administrative controls with PSN prior approval. Early in the week, one MOS observer questioned whether this policy was being followed correctly. Further investigation by all MOS observers concluded that deviations from procedures, when required, are being conducted properly, and that procedure usage in general is very good. The requirement to obtain PSN approval prior to deviating from a procedure was reemphasized during shift briefings.

ATTACHMENT: MOS DAILY REPORTS

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MANAGEMENT ON SHIFT (MOS)

WEEK STARTING: December 7, 1987

WEEKLY SUMMARY REPORT

PAGE 2 OF 2

- Maintenance supervisors need to provide better reports at the shift briefings.
- The Shift Director must do a better job of keeping the control room informed.
- Plastic placed around new insulation to keep it dry was found to be full of water.
- Ten separate procedures must be used to reduce load from 100% to Hot Standby. Many are entered to perform only one or two steps.

Plant operation and support continues to improve as indicated by 30 occasions of observed "Strengths" by the MOS observers. One particular situation concerning a leaking primary water valve demonstrated the professional attitude, attention to detail, diagnostic ability and teamwork of the Control Room crew.

ATTACHMENT: MOS DAILY REPORTS

To: Operations Superintendent - Nuclear

Date: 12/07/87

From: K.J. Wiecek
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant evolutions observed**

- Attended morning meeting
- Attended pre-shift operations meeting
- Unit #4 steady state operations, and Unit 3 in mode 5
- Performed secondary side walk-down on both Units
- Discussed surveillance monitoring with OPS-QC

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

E. Strengths

Observed good communications between the PSN, APSN, NWE and the rest of the shift operators starting with the pre-shift meeting and continuing throughout the day during routine normal operations.

F. Areas for improvement

None

G. Recommendations

None

Completed By: K.J. Wiecek
MOS Observer

Date: 12/07/87

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 12/8/87

12/07/87

To: Operations Superintendent - Nuclear

Date: 12/07-08-87

From: William Detwiler
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- Heat up of Unit 3 RCS
- Tour of secondary side of Plant
- High containment pressure test, OP-4004.4

B. Immediate safety problems

None observed

C. Questionable work practices

Paper is used to cover the control room floor for several hours to keep the carpet clean. The paper is a fire hazard because it is untreated and a tripping hazard because it tends to bunch up.

D. Actions taken

Informed PSN of concern about paper on floor of control room.

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E. Strengths

- The PSN used the "hot items" list well for maintenance items that need immediate attention.
- The use of an Administrative Technician is a good practice because it reduces the paperwork load of the PSN, APSNs and RCOs.
- Missing page of a procedure was discovered by an alert APSN while performing the procedure. This demonstrated alertness and an assuming attitude.

F. Areas for improvement

- The practice of working auxiliary operators and maintenance personnel 16 hours a day should be reviewed. Personnel working these kind of hours can become overly tired and less alert. This can make them more prone to mistakes. For some personnel working 16 hours straight occurs fairly frequently (1-2 times a week).
- There seems to be no guidelines that determines which procedures are guidance only procedure and which are sign off procedures. Guidelines should be established or if they exist, should be communicated to operations personnel.
- A system walkdown procedure was performed but not placed in the walkdown book. This led to confusion and almost caused the PSN to redo the procedure. More attention should be paid to this type of paperwork.

G. Recommendations

None

Completed By: William Detwiler
MOS ObserverDate: 12/08/87Reviewed By: *Bill Plume*
Operations Superintendent-NuclearDate: 12/8/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/07-08/87

From: L.L. Thomas
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant evolutions observed

- Ends of shift meeting
- APSN turnover
- Beginning of shift meetings
- 4-OSP-041.1 RCS leak rate calculation
- OP-4004.4 containment isolation racks QR50 and 51 test

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

E. Strengths

Shift meetings are working very well

F. Areas for improvement

None observed

G. Recommendations

None

Completed By: L.L. Thomas
MOS Observer

Date: 12/08/87

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 12/8/87

To: Operations Superintendent - Nuclear

Date: 12/08/87

From: K.J. Wiecek
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant evolutions observed

- Morning meeting
- Preshift operators meeting
- Reviewed operators overtime log book
- Unit 4 steady state power; Unit 3 Mode 5
- Plant tour - accessible portions of RAB and secondary

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

E. Strengths

None noted

F. Areas for improvement

Attached is a follow-up on MOS report by William Detwiler dated 12/07-08/87.

G. Recommendations

None

Completed By: K.J. Wiecek
MOS Observer

Date: 12/08/87

Reviewed By: J.W. Pearce
Operations Superintendent - Nuclear

Date: 12/8/87

F. Areas for improvement

Response to Attached MOS report of 12/07-08/87

1. I reviewed the Operations Department overtime log book for the period of 11/30/87 thru 12/08/87. There was only one instance where a non-licensed operator had to work a 16 hour shift. There were a number of 12 hour shifts worked during this period also, which is normal during the start-up of a plant. The overtime limitations established in AP-0103.2, section 8.3.1. were being followed during this period.
2. When a step or section of a procedure requires a signature, a signature space will appear next to the step or section of the procedure.

Section 2.2 of all O.P's, G.O.P's, O.S.P's etc., establishes which sections of the procedure are retained as Q.A. records. As a rule, if there are sign-off's in a procedure, it is retained. The remainder of the procedure does not have to be retained and therefore does not require sign-off's.

3. I agree with his recommendation.

K.J. Wiecek Attachment - A

E. Strengths

- The PSN used the "hot items" list well for maintenance items that need immediate attention.
- The use of an Administrative Technician is a good practice because it reduces the paperwork load of the PSN, APSNs and RCOs.
- Missing page of a procedure was discovered by an alert APSN while performing the procedure. This demonstrated alertness and an assuming attitude.

F. Areas for improvement

- The practice of working auxiliary operators and maintenance personnel 16 hours a day should be reviewed. Personnel working these kind of hours can become overly tired and less alert. This can make them more prone to mistakes. For some personnel working 16 hours straight occurs fairly frequently (1-2 times a week).
- There seems to be no guidelines that determines which procedures are guidance only procedure and which are sign off procedures. Guidelines should be established or if they exist, should be communicated to operations personnel.
- A system walkdown procedure was performed but not placed in the walkdown book. This led to confusion and almost caused the PSN to redo the procedure. More attention should be paid to this type of paperwork.

G. Recommendations

None

K.J. Wiecek Attachment - B

Completed By: William Detwiler
MOS ObserverDate: 12/08/87Reviewed By: *S.W. Preece*
Operations Superintendent- NuclearDate: 12/9/87

gjb 12/9/87

7/13/14/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/08-09/87

From: William Derwiler
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- ° Draining RHR header
- ° Release of gas decay tank
- ° Inducing Xenon oscillations to perform flux map
- ° Shift turnover

B. Immediate safety problems

None observed

C. Questionable work practices

While performing a release of a gas decay tank the CRO deliberately skipped a step in 3-OSP-67.51 which is required to be performed by OP-5523.1 "Releasing a Gas Decay Tank" without prior approval by the PSN. He made a notation in the comments space explaining why he did not perform this step. This is a violation of O-ADM-201 Upgrade of Operations Procedure Usage for two reasons:

1. CRO should not have skipped step
2. CRO did not confer with PSN before skipping step

D. Actions taken

Informed PSN. PSN advised CRO of mistake and asked the relieving PSN to advise his CROs not to make the mistake.

E. Strengths

Communications were conducted well

F. Areas for improvement

- Clarification of yesterday's (12/08/87) comments on procedure verification. When non-safety related procedures were written some require a step-by-step verification and others required only a signature at the end of the procedure. O-ADM-101 states that those procedures deemed appropriate by the Operations Supervisor are to be written with step-by-step verification. There are no specific guidelines.
- The inducing Xenon oscillations to produce various Incore Axial Offsets, OP-12304.8 does not specifically reference OP-12404.1 which is the procedure for performing a flux map. It simply states to "Begin a flux map".

G. Recommendations

Procedures that are signed off only on their back page are being microfilmed in their entirety. This results in the exact same front pages of the same completed procedures being repeatedly microfilmed. My recommendation is to microfilm only the last page of these types of procedures.

Completed By:

William L. Detwiler

MOS Observer

Date: 12/09/87

Reviewed By:


Operations Superintendent-Nuclear

Date: 12/9/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/08-09/87

From: L.L. Thomas
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant evolutions observed

- End of shift meeting
- PSN/APSN turnover
- 3-OSP-067.1 process radiation monitor test
- Preshift briefing
- OS-12304.8 inducing Xenon Oscillation to produce various incore axial offsets

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

E. Strengths

None observed

F. Areas for improvement

None

G. Recommendations

None

Completed By: L.L. Thomas
MOS Observer

Date: 12/09/87

Reviewed By: *[Signature]*
Operations Superintendent - NuclearDate: 12/9/87

To: Operations Superintendent - Nuclear

Date: 12/09/87

From: K.J. Wiecek
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant evolutions observed**

- Morning meeting
- Preshift meeting
- Plant tour of Unit 3 steam trestle, intake area and "A" and "B" Diesel Generator buildings.
- Peak shift meeting
- Unit 4 steady state power, Unit 3 in Mode 5

B. Immediate safety problems

None observed

C. Questionable work practicesMOS Report Clarification

The step described in MOS report of 12/08-09/87 (Detwiler) was step 7.3.17 of 3-OSP-067-1 which has the operator close and lock the air supply valve to RCV-014. The reason he did this (which was noted on 3-OSP-067.1 in accordance with Admin-201, step 5.25.1. and b) was to continue on with OP-5523.1 which has you Re-open the air supply to RCV-014 on step 8.1.10.1 to initiate a gas release.

D. Actions taken

A procedure change was initiated to allow the operator to "N/A" step 7.3.17 of 3-OSP-067-1, if the functional test on R-3-14 was performed as a prerequisite to a Gas Decay Tank release.

12/09/87

E. STRENGTHS

- The control room entry door would not close and lock properly and a security guard was promptly posted at the door until repairs could be made.
- Overall plant cleanliness is outstanding

Significant Event

While an I&C Spec. was working on PRM-19, an apparent ground occurred opening a breaker which deenergized all process radiation monitors. This caused a Containment/Control Room Isolation to occur.

This is reportable under AP-0103.12, an automatic activation of any engineer's^{ed} safety feature.^{ph}

Although I did not witness the actual occurrence it appears that the operators carried out the correct actions and made the proper notifications.

F. Area(s) for improvement

None observed

G. Recommendations

None

Completed By: K.J. Wiecek
MOS ObserverDate: 12/09/87Reviewed By: J. W. Pearce
Operations Superintendent - NuclearDate: 12/10/87

FINAL PAGE

12/09/87

To: Operations Superintendent - Nuclear

Date: 12/09-10/87

From: William Detwiler
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- Completion of flux mapping
- Purging VCT
- Plant tour

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

12/09-10/87

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E. Strengths

PSN took quick and decisive action to correct low electrolyte battery level and referred to Technical Specifications to ensure he was within operable limits concerning the battery level in spite of some confusion on what is minimum level.

F. Areas for improvement

Electrolyte of "4A" battery was found to be low. The electrical maintenance procedure O-SME-003.2 states that the acceptance criteria is above the top of the plates. The interim Technical Specifications, on the other hand, states that action must be taken to restore the level if not greater than minimum level. This is causing confusion as to what is the minimum level. Electrical Supervisor will be informed so that the confusion in the procedure can be resolved.

Also the Turbine Operator logs do not give a minimum specification for when electrolyte level is too low. A specification should be made that is slightly above the minimum level line.

G. Recommendations

None

Completed By: William Detwiler
MOS Observer

Date: 12/10/87

Reviewed By: J. W. Pearson
Operations Superintendent- Nuclear

Date: 12/10/87

12/10/87
12/10/87
FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/09-10/87

From: L.L. Thomas
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- End of shift meeting
- Watch turnover
- Preshift meeting
- Unit 3 Mode 5
- Unit 4 steady state operations

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

E. Strengths

ASPN held good tailboard meeting with operator prior to setting the TCV2201 valve watch i.e. duties, responsibilities, communication requirements etc.

PSN required I&C, Electrical and Mechanical Maintenance Supervisors on shift to report their assignments for the shift.

F. Areas for improvement

O-SME-003.2 125 VDC station-battery monthly maintenance procedure needs to be reviewed to ensure compliance with Interim Technical Specifications.

G. Recommendations

See item F.

Completed By: L.L. Thomas
MOS Observer

Date: 12/10/87

Reviewed By: *J.W. Pearce*
Operations Superintendent- Nuclear

Date: 12/10/87

7/15 12/10
12/10/87
FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/10/87

From: K.J. Wiecek
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant evolutions observed**

- Morning meeting
- Pre-shift meeting
- Unit 4, steady state power; Unit 3, Mode 5
- Plant tour of Water Plant, Switchgear and MCC Rooms.
- Partial walk down of O-ONOP-103 "Control Room Inaccessibility" Procedure.
- Peak pre-shift meeting

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

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E. Strengths

I expressed a few concerns I had with the "Control Room Inaccessibility" Procedure, O-ONOP-103 to the APSN, and he explained that the new Remote Shutdown System has not been fully implemented and all improvements are not complete. His knowledge of the procedure and system awareness were excellent.

F. Areas for improvement

None

G. Recommendations

None

Completed By: K.J. Wiecek
MOS Observer

Date: 12/10/87

Reviewed By: L.W. Fause
Operations Superintendent- Nuclear

Date: 12/11/87

12/11/87 7:30 12/11/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/10-11/87

From: William Detwiler
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- Operability test Source Range NIS
- Testing Auxiliary Transformer
- Recircing a base for sampling

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

E. Strengths

RCO when performing operability test of source range NI's alertly called in PSN when step could not be performed, received PSN approval, noted it and then proceeded with remainder of procedure. Careful attention to procedure was evident on these shifts.

F. Areas for improvement

It appears that sometimes when steps in procedures are not performed as written, the necessary PSN approval, as evidenced by PSN's initials and the date on the applicable notation, is not obtained. Also, there appears to be some confusion as to what constitutes a procedure deviation and when it can be approved by a PSN without an OTSC.

This observation was determined by interviewing several people in operations and by reviewing recent procedures, for example, 3-OSP-072.2 MSIV N2 backup periodic test performed on 10/23/87.

G. Recommendations

On procedures that affect many other procedures such as the Upgrade Operations Procedure Usage, O-ADM-201, any changes that are made should be explained, not just stated, in a training brief and in pre-shift meetings as soon as possible after changes have been made.

Completed By: William Derwiler
MOS Observer

Date: 12/11/87

Reviewed By: R.W. Pearce
Operations Superintendent- Nuclear

Date: 12/11/87

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FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/10-11/87

From: L.L. Thomas
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant evolutions observed

- 3-OSP-059.1 Source Range Nuclear Instrumentation Analog Channel Operational Test
- 3-OP-065.2 AFW and MSIV Backup Nitrogen Gas Supply System
- End of shift meeting
- Pre-shift meeting

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None

E. Strengths

RO showed excellent judgment when he ran into a step in procedure, 3-OSP-059.1 Source Range Nuclear Instrumentation Analog Channel Operational Test, to verify Annunciator "off" that could not be accomplished due to other source range out of specification. He called PSN and got out procedure O-ADM-201, Upgrade Operations Procedure usage, and applied step 5.29 which addressed this exact condition.

F. Areas for improvement

None

G. Recommendations

None

Completed By: L.L. Thomas
MOS Observer

Date: 12/11/87

Reviewed By: *J.W. Pearce*
Operations Superintendent - Nuclear

Date: 12/11/87

To: Operations Superintendent - Nuclear

Date: 12/11/87

From: K.J. Wiecek
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant evolutions observed**

- Morning meeting
- Pre-shift meeting
- Plant tour of Auxiliary Building, Gas House and various secondary systems
- Control Room operations, Unit 4 steady state power; Unit 3 Mode 5

B. Immediate safety problems

None observed

C. Questionable work practices

None observed

D. Actions taken

None observed

E. Strengths

Professional attitude exhibited by all shift operators observed.

F. Areas for improvement

None

G. Recommendations

None

Completed By: K.J. Wiecek
MOS Observer

Date: 12/11/87

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 12/14/87

To: Operations Superintendent - Nuclear

Date: 12/11-12/87

From: William Derwiler
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- Power range NI Analog Channel Operational Test, 4-OSP-059.4
- Charging chemicals to pressurizer through auxiliary spray
- Secondary Plant Periodic Test - Lube Oil Pumps Auto Start Test, 4-OSP-200.3
- Shift meetings
- Plant tour

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

Operators were very careful and attentive to detail whenever performing procedures.

F. Areas for improvement

None

G. Recommendations

I suggest that when performing procedures in the field that the person performing the procedure could get verbal approval from the PSN if deviation in procedure is necessary. The PSN could then initial the notation after the procedure is completed. This will allow flexibility to perform procedures without making people come back to the Control Room to get written approval. This could be incorporated into O-ADM-201.

Completed By: William L. Derwiler
MOS Observer

Date: 12/12/87

Reviewed By: J.W. Pearce
Operations Superintendent - Nuclear

Date: 12/14/87

To: Operations Superintendent - Nuclear

Date: 12/11-12/87

From: L.L. Thomas
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- 4-OSP-059.4 Power Range Nuclear Instrumentation Analog Channel Operational Test (N-44 section)
- 3-OP-065.2 AFW and MSIV Back Nitrogen Gas Supply System
- 4-OSP-200.3 Secondary Plant Periodic Test - Lube Oil Auto Start

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

Effective Pre-shift meetings, Plant status and future plans well covered.

F. Areas for improvement

1. Maintenance Department Supervisors need to report what they are working on at the pre-shift meetings. When they do not the APSN needs to ask them.
2. Shift director needs to keep PSN/APSN better informed of status through the shift.

G. Recommendations

None

Completed By: L.L. Thomas
MOS Observer

Date: 12/12/87

Reviewed By: *L. L. Thomas*
Operations Superintendent - Nuclear

Date: 12/14/87

To: Operations Superintendent - Nuclear

Date: 12/12/87From: K.J. Wiecek
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant evolutions observed**

- Morning meeting
- Pre-shift meeting
- Power reduction to 85% on Unit 4 to repair LCV-1510A
- Securing 1A Heater Drain Pump
- Isolating and Tagging out of LCV-1510A
- I&C work performed on LCV-1510A
- Stroke Test of MOV-1404
- 1B Heater Drain Pump Trip

B. Immediate safety problems

None

C. Questionable work practices

While maintenance was being performed on "B" Heater Drain Tank Level Column, the "B" Heater Drain Pump tripped.

D. Actions taken

The PSN instructed the mechanics to be more careful when working around sensitive equipment.

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E. STRENGTHS

- Uncomplicated Unit 4 power reduction to 85% power to repair LC-1510A
- Extensive Tail Board meeting on method of ensuring plant stability during the time work was being performed on LCV-1510A, i.e., number of Heater Drain Pumps running, and loader on LCV-150A, Xenon Oscillation, etc.
- Tail Board meeting payed off, because the plant conditions were such that, when "B" Heater Drain Pumps tripped, it did not cause any plant perturbations.
- While Stroke Testing MOV-1404, the Upstream Isolation Valve #2119 apparently was leaking by and when MOV-1404 was opened "A" and "C" Auxiliary Feed Pumps started to rotate. The operators noticed this immediately and took action by reclosing MOV-1404, stopping "A" and "C" Auxiliary Feed Pumps from rotating. They also consulted the Procedures and contacted Upper Management to see if there were any concerns they may have overlooked. There were none.

F. AREAS FOR IMPROVEMENT

None

G. RECOMMENDATIONS

Remind all Departments to be more careful working around sensitive equipment.

Completed By: K.J. Wiecek
MOS ObserverDate: 12/12/87Reviewed By: *Paul Pearce*
Operations Superintendent - NuclearDate: 12/14/87

CJB 12/14/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/12-13/87

From: William L. Detwiler
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- Filling 4A Accumulator
- Increasing power from 85% to 100%
- Man injured on Unit 2
- Leakby of Dilution Valve
- Secured 4A main condensate pump

B. Immediate safety problems

None

C. Questionable work practices

FCV-114A apparently leaked by causing an inadvertent dilution of the RCS. The cause is not known at this time, but improper seating of FCV-114A is suspected.

D. Actions taken

The primary water pumps were secured and isolated. All valves that could be a source of dilution water to the RCS were checked tightly closed. As no discrepancies were discovered, the primary water pumps were restarted and unisolated with no reoccurrence of leakby. A PWO was submitted to investigate the problem. The dilution flow path will be closely monitored.

E. Strengths

The RCO detected leakage past FCV-114A while performing a RCS Leak Rate Surveillance. He immediately informed the PSN. There was good team work response to the problem with good diagnostic ability demonstrated by the Operations Team. Procedure was used as much as possible. The detection and response to the problem demonstrated alertness, team work and good watch standing procedures.

F. Areas for improvement

None

G. Recommendations

None

Completed By: William L. Detwiler
MOS Observer

Date: 12/13/87

Reviewed By: *J. W. Purcell*
Operations Superintendent- Nuclear

Date: 12/14/87

CJB 12/14/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/12-13/87From: J. Reed
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- Pre-shift brief
- Power escalation 85% to 100%
- Shift turnover
- Turbine Control Valve Testing 3-OSP-089
- Daily RCS Leak Rate Check
- Corrective actions for RCS in-leakage
- Air Evacuation of injured man from Fossil Unit

B. Immediate safety problems

None

C. Questionable work practices

Following the identification of an RCS in-leakage of approximately 12 Gal/hr, it was tentatively determined that FCV-114A was leaking.

D. Actions taken

PSN wrote PWO to confirm FCV-114A leaking and to repair

158

24

7

10

3

10

2

10

10

10

10

10

E. Strengths

The crew displayed excellent teamwork and diagnostic skills in locating the source of RCS in-leakage.

F. Areas for improvement

New insulation in the area above Unit 3 AFW Nitrogen station is wrapped in poly to protect it from the weather. The inside of the poly is full of liquid and all the insulation is saturated. It appears that all the insulation needs to be replaced.

G. Recommendations

None

Completed By: J. Reed
MOS Observer

Date: 12/13/87

Reviewed By: *J.W. Pearce*
Operations Superintendent- Nuclear

Date: 12/14/87

12/14/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/13/87

From: K.J. Wiecek
(MOS Observer)Shift: ☒ Day
☐ Night**A. Plant evolutions observed**

- Load reduction to 100 MWE on Unit 4 to repair stuck closed N.E. intercept valve
- Repair of and subsequent testing of N.E. intercept valve
- 4-OSP-087 "Main Turbine Valves Operability Test"
- Holding power below 50% while repairs were being made to a water box manway cover

B. Immediate safety problems

None

C. Questionable work practices

None observed

D. Actions taken

None

524

44

4

100
100
2

100
100
100

100
100
100

100
100
100

E. Strengths

None observed

F. Areas for improvement

Operators have to use no less than ten different procedures to accomplish a normal load reduction from 100% power to Hot Standby. Most of the procedures require signatures, and are entered for only one or two signatures per procedure. (i.e. stopping a Heater Drain Pump, or Main Feed Pump).

G. Recommendations

Procedure process should be simplified where by the operator should only have to follow one procedure instead of jumping in and out of many procedures to perform a routine evolution such as a Load Reduction.

Completed By: K.J. Wiecek
MOS Observer

Date: 12/13/87

Reviewed By: *S. J. P. [Signature]*
Operations Superintendent - Nuclear

Date: 12/14/87

CJB 12/14/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/13-14/87

From: William Detwiler
(MOS Observer)Shift: ☐ Day
☒ Night**A. Plant evolutions observed**

- Increasing power from 50% to 100% on Unit 4
- Failure of pressurizer water temperature indication - Unit 3
- Drained "3C" SI Accumulator
- Securing Turbine Plant Cooling Water Pump

B. Immediate safety problems

None

C. Questionable work practices

None

D. Actions taken

None

E. Strengths

Good adherence to procedure when pressurizer water temperature failed. PSN stopped the heat up because the procedural requirement for plotting pressurizer temperature could not be met. The vapor space temperature was PWO'd at the time.

An alert RCO on Unit 3 realized that draining "C" accumulator without pressure in it could result in a vacuum being formed inside of the accumulator. The RCO immediately informed the PSN. The PSN directed the draining to be stopped and pressurized the accumulator with Nitrogen before proceeding. This demonstrated alertness and sound thinking.

F. Areas for improvement

None

G. Recommendations

None

Completed By: William Detwiler
MOS Observer

Date: 12/14/87

Reviewed By: *S. W. Pierce*
Operations Superintendent- Nuclear

Date: 12/14/87

WJB 12/14/87

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 12/13-14/87

From: J. Reed
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant evolutions observed

- Shift turnover (2)
- Shift meetings (2)
- Power escalation to 100%
- Pressurizer heatup
- Corrective actions for forklift accident

B. Immediate safety problems

None

C. Questionable work practices

Breaks failed on a parked forklift causing it to crash through an RCA gate.

D. Actions taken

Both H.P. and Security responded well and appropriately. PSN is taking follow up actions.

E. Strengths

Power escalation was conducted in a very professional manner.

F. Areas for improvement

None

G. Recommendations

None

Completed By: J. Reed
MOS Observer

Date: 12/14/87

Reviewed By: J. W. Pearce
Operations Superintendent - Nuclear

Date: 12/14/87

Management-on-Shift (MOS)

ACRONYMS

AEO	Auxiliary Equipment Operator	NOP/NOT	Normal Operating Pressure/Normal Operating Temperature
AFW	Auxiliary Feedwater	NPO	Nuclear Plant Operator
ANPO	Assistant Nuclear Plant Operator	NPS	Nuclear Plant Supervisor
APSN	Assistant Plant Supervisor Nuclear	NRC	Nuclear Regulatory Commission
ASP	Administrative Plant Supervisor Procedure	NS	North-South
CCW	Component Cooling Water	NVE	Nuclear Watch Engineer
CP	Charging Pump	OMS	Overpressure Mitigating System
CVCS	Chemical Volume Control System	ONOP	Off Normal Operating Procedure
DG	Diesel Generator	OOS	Out-of-Service
DC	Direct Current	OTSC	On The Spot Change
DP or DP	Differential Pressure	PI	Polarization Index
ECCS	Emergency Core Cooling System	PM	Preventative Maintenance
EDG	Emergency Diesel Generator	PNSC	Plant Nuclear Safety Committee
ERT	Event Response Team	PORV	Power Operated Relief Valve
EW	East-West	PPM	Parts Per Million
FCV	Flow Control Valve	PRZ	Pressurizer
FPL	Florida Power and Light Company	PUP	Procedure Upgrade Program
FSAR	Final Safety Analysis Report	PWO	Plant Work Order
GEMS	Generating Equipment Management Systems	QSPDS	Qualified Safety Parameter Display System
GPM	Gallons Per Minute	RCA	Radiation Control Area
HCV	Hand Control Valve	RCO	Reactor Control Operator
HHSI	High Head Safety Injection	RCP	Reactor Coolant Pump
HX	Heat Exchanger	RCS	Reactor Coolant System
IAM	In Accordance With	RHR	Residual Heat Removal
ICW	Intake Cooling Water	RTD	Resistance Temperature Device
ICWP	Intake Cooling Water Pump	RV	Reactor Vessel
IST	Inservice Testing	SAS	Safety Assessment System
LCV	Level Control Valve	S/G	Steam Generator
MCC	Motor Control Center	SGFP	Steam Generator Feed Pump
MG	Motor Generator	SIS	Safety Injection System
MSIV	Main Steam Isolation Valve	SNOW	Short Notice Outage Work
MOS	Management on Shift	SNPO	Senior Nuclear Plant Operator
MOV	Motor Operated Valve	STA	Shift Technical Advisor
NAB	Nuclear Administration Building	TOP	Temporary Operating Procedure
NANAS	National Warning System (Emergency Planning)	TSA	Temporary System Alteration
NCR	Non-Conformance Report	TP	Temporary Procedure
NIS	Nuclear Instrumentation System	VCT	Volume Control Tank
NO	Nuclear Operator	W	Westinghouse Corporation