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 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
 AUTH. NAME AUTHOR AFFILIATION
 CONWAY, W.E. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION
 ERNST, M.L. Region 2, Ofc of the Director

SUBJECT: Forwards summary of mgt-on-shift repts, per 871019 order.

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*Orig.
To Region 2*

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NOVEMBER 7 1988

L-88-491

Mr. Malcolm L. Ernst
Acting Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta Street, N. W., Suite 2900
Atlanta, Georgia 30323

Dear Mr. Ernst:

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

Pursuant to the Nuclear Regulatory Commission Order dated October 19, 1987, the attached summary of Management-on-Shift (MOS) reports is submitted. The Plant Supervisor-Nuclear Shift Reports are also being submitted.

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

Very truly yours,

W. F. Conway
Senior Vice President - Nuclear

WFC/RHF/gp

Attachment

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

mos001

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PDR ADOCK 05000250
R PNU

*Original
To: Region 2*

DA36

an FPL Group company

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMMARY REPORT

WEEK STARTING: 10/28/88

PAGE 1 OF 1

Four MOS Observers were on shift. D. R. Powell, Operating Experience Feedback Coordinator, Juno Beach (10/28-31/88, days); R. P. Sackschewsky, Westinghouse Electric Corporation (10/28-31/88, nights); J. B. Hosmer, Director of Nuclear Engineering, Juno Beach (11/01-03/88, days); J. W. Patterson, Westinghouse Electric Corporation (10/31-11/04/88, nights).

Unit 3 remained in mode 5 and Unit 4 remained defueled for the duration of the reporting period. No immediate safety problems were noted.

The observers did not note any questionable work practices. They did note thirteen areas for improvement, as follows:

- Two items on cleanliness control
- Two items on contamination control
- One item on personnel safety
- Two items on health physics support
- Two items on communication
- One item on drawings
- Two items on control of manpower
- One item on assignment of work orders

The Plant Supervisors-Nuclear noted one questionable work practice on the issuance of letters to the control room that lack clarity and are open to interpretation. They also noted six areas for improvement, as follows:

- One item on hardware breakage, repeated by an observer
- Two items on document control
- One item on spare parts
- One item on communication
- One item on work controls

Date 10/28/88

Shift Report

Shift

Ed Lyons
Days

Shift Management

SN

Wogan

APSN

Singer

NWEtromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

(1)

Reviewed By _____ Date _____

Date 10/28/88

Shift Report

Shift Peaks

Shift Management

SN Schimkus APSN Reese NWE Newton

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Tonight an effort was made to expedite the removal of PORV-3-456 to allow inspection/repair. The progress moved swiftly to process the applicable paperwork, OTSCs, etc. People were actually dressing out to start work when it was discovered during PSN, PWO review, that no clearance request was submitted, i.e., no clearance hung to perform the work. This was partially due to the clearance releases required to perform multiple stroke tests across mid/day shift on 10/28/88. This appears to have been overlooked (clearance re-hung) due to the constantly changing workscope for PORV-456 all day.

Recommendation: Slow down - do it right.
(88-2919)

C. Good Practices/Professionalism Observed

Would like to show appreciation to Mechanical Maintenance and I&C peak shift supervision for staying on top of PORV-456 work progress. Although we had one minor hitch due to no clearance request for work, the Nuclear Operators/RCO worked quickly to initiate the required clearances and hung these clearances on the pressurizer so work could start.

2

Reviewed By _____ Date _____

To: Operations Superintendent - Nuclear

Date: 10/28/88

From: David Powell
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5; unit 4, defueled
- Unit 4 containment entry - tour
- Spent fuel pool - work on installing equipment
- Shift turnovers and briefings
- Various ongoing maintenance activities
- Radiation Control Area (RCA) tours

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Shift briefings were lengthy but detailed and informative. Personnel from Health Physics have not been routinely attending the meetings that I have witnessed. Their comments about any HP concerns on on-going jobs would be helpful, especially if they have been experiencing any problems.
(88-2922)

Other work seems to have been conducted without major problems or obstacles. A good days worth of activity from what I saw and reviewed.

(17)

Completed By: David Powell
MOS Observer

Date: 10/28/88

Reviewed By: Operations Superintendent - Nuclear

Date:

Management
Review By:

PM-N 1/12/89 Date SVP 1/10/89 Date VP 1/10/89 Date

10/28/88

To: Operations Superintendent - Nuclear

Date: 10/28-29/88

From: Roy Sackschewsky
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 4, defueled
- Unit 3 in mode 5
- Shift turnover
- Unit 3, containment tour
 - Removing insulation from pressurizer
- Turbine platform tour
- Control room operations

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Shift turnover was well organized and progressed smoothly. Priority lists for both units were made available.

During an Auxiliary Building tour it was noted that the door to the containment Self Contained Breathing Apparatus cabinet was broken from its hinges. It was suggested that the Scott air packs stored in the cabinet have seals placed on their handles to ensure the user that they are ready for use. The Nuclear Watch Engineer directed Health Physics to complete this action.

(18)

Completed By: Roy Sackschewsky
MOS Observer

Date: 10/28-29/88

Reviewed By: Operations Superintendent - Nuclear

Date:

Management
Review By:

KC 10/31/88 SVP 10/31/88 VP
PM-N Date Date Date

10/28-29/88

Shift Report

Date 10/29/88

Shift Mids

Shift Management

SN Jones

APSN Haley

NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

3

viewed By Date

Shift _____ Days _____

Shift Management

SN _____ Wogan _____ APSN _____ Singer _____ NWE _____ Vetromile _____

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

4

viewed By _____ Date _____

Date 10/29/88

Shift Report

Shift Peaks

Shift Management

SN Schlmkus APSN Reese NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Tonight early on peak shift, Construction accidentally broke a hole in the plant fire protection water main as they were performing excavation work. The APSN and NWE immediately took steps to isolate the leak. One complete pass of isolating the leak perimeter valves was unsuccessful. A second pass was made giving double valve isolation to the leak still with no success. All the perimeter valves were exercised and closed to accomplish isolation in the event of debris under valve seats, still no success. Both fire pumps had to be secured to lower pressure of fire main to allow pipe removal.

Action: Put PWOs on PIV-28 and 25 to inspect valve seats.

Recommend: If problem found due to calcium carbonate build-up, we should inspect all PIVs in system.
(88-2920)

C. Good Practices/Professionalism Observed

The fire main break was handled in a quick, step by step, professional manner by the peakshift APSN, NWE, ANPO. The NWE utilized a clearance to allow valve manipulations, etc., which enabled a valid work control plus isolation of the leak. The FPL and Bechtel Construction Supervisors were immediately on hand to commence pipe removal/repair. The APSN utilized much common sense (not written in procedure) to have all groups stop any hot work. The plant was informed by plant page of the situation and requested to stop all cutting, grinding, welding, etc., which could be a fire source. There were numerous instances of doing the right actions by all personnel involved. Good communication and professionalism.

(5)

Reviewed By _____ Date _____

To: Operations Superintendent - Nuclear

Date: 10/29/88

From: David Powell
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5, unit 4, defueled
- Shift turnovers
- Reactor Coolant Pump (RCP) seal replacement work
- J - nozzle work
- Unit 4 containment tour
- Radiation Control Area (RCA)/plant tours
- Various maintenance evolutions

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Shift turnovers and briefings were thorough and complete. Work efforts appear to have progressed smoothly throughout the day.

The fire main was broken toward the end of my shift. Efforts by the PSN, APSN, Watch Engineer, etc. to resolve this problem progressed logically. Actions taken were well thought out and coordinated.

(19)

Completed By: David Powell
MOS Observer

Date: 10/29/88

Reviewed By: Operations Superintendent - Nuclear

Date:

Management
Review By:

PM-N 10/31/88 SVP 10/31/88 VP 10/29/88

To: Operations Superintendent - Nuclear

Date: 10/29-30/88

From: Ray Sackschewsky
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4, defueled
- Control room operations
 - Fire main rupture
 - 3-OSP-041.4
- Unit 4 containment tour
 - Reactor Coolant Pump (RCP) seal removal
 - Steam Generator (S/G) - J-Tube repair
 - S/G Eddy current test
- Fire main repair

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

All "Hot Work" was stopped for the evening due to the Fire Main problem. The operational staff approach to the problem was thorough, well thought through and conservative. Operating staff kept informed of progress throughout the shift.

(20)

Completed By: Roy Sackschewsky
MOS Observer

Date: 10/29-30/88

Reviewed By: Operations Superintendent - Nuclear

Date:

Management
Review By:

KC 10/31/88 SVP 10/31/88 VP 10/31/88
PM-N Date Date Date

10/29-30/88

Date 10/30/88

Shift Report

Shift Mids

Shift Management

'SN Jones APSN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

6

Reviewed By _____ Date _____

Shift Report

Date 10/30/88

Shift _____ Days _____

Shift Management

PSN Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

⑦

Reviewed By _____ Date _____

Date 10/30/88

Shift Report

Shift PeaksPSN Schimkus Shift Management Reese Vetromile
APSN NWE**A. Questionable Work Practices/Actions Taken/Recommendations**

None

B. Areas for Improvement/Recommendations/Actions Taken

PORV-3-455C was suspected to be binding on Friday, 10/03/88. A decision was made not to pull PCV-3-455A blank flange due to worker exposure, which would allow a constant controllable 2.2 sq. in. RCS opening while both PORVs were being worked. The PORV-455C work was to be of short duration. The 2.2 sq. in. opening was to be the PORV-456 open body (valve removed for repair). Tonight, multiple problems were discovered on PORV-455C due to a defective pressure indicator on the nitrogen regulator. The PSN consulted with numerous members of our plant management to arrive at a solution to make PORV-455C an operable vent path in lieu of its failed pressure indicator. The action plan per responsible departments was to OTSC the applicable procedures to allow a calibrated portable gage be installed each day to verify actual pressure (nitrogen) after which the gage would be removed till surveillance scheduled on the next day. During the pressure check, PORV nitrogen would be isolated to allow gage installation, open nitrogen supply and verify pressure, close nitrogen supply and remove gage followed by re-opening nitrogen supply. The shift director felt that while nitrogen is isolated, the 2.2 sq. in. RCS vent is inoperable. Technical Specifications state that if both PORVs become inoperable - Open the PORV and its associated block valve. ADM-021 only informs to provide a 2.2 sq.in. opening and surveillance is every 12 hours to ensure opening is maintained.

Due to PORV-3-456 being ready for installation on 10/31/88 midshift, (peakshift) PSN had made the decision to allow installation until shift directors safety concern. The PSN contacted all individuals of Regulation and Compliance and they agreed with the shift director that we could not take credit for PORV-455C vent path until both nitrogen and instrument air was totally operable. The PSN requested that the original plan of pulling PCV-455A flange be pulled to allow work on both PORVs and maintain Technical Specification vent path.

Recommend:

1. Technical Specifications or licensing letter have written instructions concerning PORV back up nitrogen system operability information.
(88-2923)

2. When a job on critical path or extremely close to critical path commences to cause a problem due to operability concerns, be re-evaluated immediately by the shift director who in turn should coordinate the maintenance group activity. This would involve notifying the PSN of the problem and actions to be taken. The PSN can then evaluate the Technical Specifications involved.
(88-2924)

(8)

Reviewed By _____ Date _____

Shift Report

Date 10/30/88

Schimkus

Page 2

Continuation Page

3. If policy is to be more conservative than what is written in Technical Specifications, then write this down. If not, then inform all plant personnel that the PSN shall follow Technical Specifications word-for-word.

(88-2925)

C. Good Practices/Professionalism Observed

None

9

To: Operations Superintendent - Nuclear

Date: 10/30/88

From: David Powell
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5, Unit 4, defueled
- Containment tour, unit 4
- Radiation Control Area/plant tours
- Shift turnovers

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Shift turnover/briefings were very good. The fire main was brought into service without any problems. Quiet day overall.

(21)

Completed By: David Powell
MOS Observer

Date: 10/30/88

Reviewed By: Operations Superintendent - Nuclear

Date:

Management
Review By:

PM-N 10/31/88 SVP 10/31/88 VP 10/31/88

Date Date Date

10/30/88

To: Operations Superintendent - Nuclear

Date: 10/30-31/88

From: Roy Sackschewsky
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4 defueled
- Tour turbine deck
- Tour auxiliary building
- Tour Radiation Control Area (RCA)
-Power Operated Relief Valve (PORV) work observed
- Control room operations
- Shift turnover

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Shift turnover went smoothly. Work is focusing on unit 3 PORV replacement and testing. Very little contract work being completed on Sunday evening.

It was noted that seals have been placed on the Scott air packs as recommended earlier in the week.

Completed By: Roy Sackschewsky
MOS Observer

Date: 10/30-31/88

22

Reviewed By: Operations Superintendent - Nuclear

Date:

Management
Review By:JSC
PM-N10/31/88
Date

SVP

10/31/88
Date

VP

1
Date

10/30-31/88

Date 10/31/88

Shift Report

Shift Mids

Shift Management

PSN Jones APSN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

16

Reviewed By Date

Date 10/31/88

Shift Report

Shift Ed Lyons
Days

Shift Management

PSN Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

①

Reviewed By Tim Hesse

Date 11/1/88

Date 10/31/88

Shift Report

Shift _____ Peaks _____

Shift Management

PSN Anderson APSN Dallau NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

The Procedure Basis Documents in the control room are not controlled documents. Many times these documents are used to interpret steps and requirements of procedures to prevent LERs and violations. Due to this importance I think it would be pertinent to have them accurate and up to date.
(88-2959)

C. Good Practices/Professionalism Observed

Again, I think J. Webb and Operations support should be recognized for their continuing effort to keep operations up to date on outage work and plans.

(2)

viewed By Spence

Date 11/1/88

To: Operations Superintendent - Nuclear

Date: 10/31/88

From: David Powell
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5; unit 4, defueled
- Radiation Control Area (RCA) tour
- Plant tour
- Removal of lifting rig from unit 4
- Shift turnover and briefing

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. The unit 4 personnel access hatch dressout area should be more thoroughly cleaned. This area has not been used for unit 4 access during the past few days and does not look like it received a good cleanup following the termination of its use. This area has been like this for four or five days.
(88-2926)
2. I noted several items during the removal of a lifting rig from unit 4 today:
 - a. It took over 25 minutes for Health Physics to arrive to the equipment hatch to monitor the removal work. Waiting for the HP to arrive were: 5 Bechtel journeymen, a crane operator, an FPL Supervisor, 2 Bechtel safety people and 2 personnel who were dressed out and were to cover up the rig for transport outside the contaminated area. The FPL Supervisor indicated that he had notified HP twice that they were ready to start.
(88-2953)
 - b. Personnel safety was compromised by allowing personnel to walk under and beside the rig when it was being manipulated. At one point 5 people walked by when the rig was being moved into a horizontal position. Two cranes were being used to do this and two spotters were necessary to direct the crane operators. The rig was not overly stable during this operation. I went over to one of the Bechtel safety people and asked why people were being allowed access while this was occurring. He did not know but I think he mentioned something to the personnel, as ingress/egress was then stopped. During these evolutions, access needs to be halted, or at least limited to ensure personnel safety. This was not the case during this evolution.
(88-2954)

(4)

E. Professionalism, Summary of Shift, Comments

Shift turnovers and briefings were good.

General comments from a week of touring the plant:

1. A large number of times I've noted people standing around waiting for something to do. At times there have been many (example: fire main pipe break - 12 to 20 people for at least 30 minutes) or a few (example: 3 journeymen, QC inspector, guard, FPL Construction Supervisor waiting for an operator to do a partial release on the Steam Generator S/G code safeties. This was in order to install the air movers to support the J-Nozzle effort. I waited there 25 minutes. I'm not sure how long after I left it took to get the operator there). Supervisors need to be asking-"why," when they see this occur. I'm not sure that this is being done, and I never observed a supervisor doing this. At times it also seemed like there were an inordinate number of people being used to perform a given task.

(88-2955)

2. The ALARA area coordinator position seems to be very effective. These people are knowledgeable, aggressive and conscientious.

3. I've noticed personnel inside containment or in the roped off areas who have their PCs partially unzipped. Some of these people are HPs. The St. Lucie response to this practice was to have personnel tape the zippers.

(88-2956)

4. During my containment tours I talked with the HP ALARA personnel who spend a lot of time at different stations. I asked these people if they have seen many FPL Supervisors or safety personnel in containment. With the exception of the superintendents, they indicated that they see these people very infrequently.

(88-2957)

5

Completed By: David Powell
MOS Observer

Date: 10/31/88

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

Date: 11/1/88

Management
Review By:

1 *[Signature]* 11/1/88
PM-N Date SVP Date VP Date

10/31/88

To: Operations Superintendent - Nuclear

Date: 10/31-11/01/88

From: John Patterson
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Units 3 and 4 shutdown
- Shift turnover briefing
- Tour of unit 4 containment
- Tour in intake structure

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Members of the plant staff took strong, decisive steps to rectify some problems identified with power operated relief valve maintenance.

(6)

Completed By: John Patterson
MOS Observer

Date: 10/31-11/01/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 11/1/88

Management
Review By:

PM-N

Date

SVP

Date

VP

Date

10/31-11/01/88

Date 11/01/88

Shift Report

Shift Mids

Shift Management

PSN Jones APSN Haley NWE

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

3

viewed By W. L. Jones

Date 11/1/88

Date 11/01/88

Shift Report

Shift _____ Days _____

Shift Management

SN Wogan APSN Singer NWE Vetromile

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

Routine operations

①

Reviewed By

[Signature]

Date

11/2/88

To: Operations Superintendent - Nuclear

Date: 11/01/88

From: John Hosmer
(MOS Observer)Shift: ☒ Day
☐ Night

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4 defueled
- Unit 3 Main Steam Isolation Valve (MSIV) stroke time testing
- -portions of Power Operated Relief Valve (PORV) testing
- Unit 4 valve maintenance
- Control room shift turnover
- 6 A.M. and 2 P.M. status meetings

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. Control room Hagan IWDs - Although no index apparently exists, it appears that one Hagan drawing, 5960036, is not available as a controlled drawing in the control room. Hagan dwg. 5610-M-430-237 references dwg. 5960036 in the lower right hand corner but the referenced drawing is not available in the control room. Operations made a phone call and immediately obtained the needed information, but felt as I did that the drawing is missing.

Recommendation: Place drawing in the control room.
(88-2829)

2. Damage assessment - Extent of damage to the unit 4 coil stack caused by a dropped metal plate was not aggressively passed to operations. Tom Wogan had to call at peak shift turnover to determine status.

Recommendation: In the 6 A.M. and 2 P.M. meetings, assign a person and a time when operations will be provided status.
(88-2960)

E. Professionalism, Summary of Shift, Comments

- The control room 3 P.M. turnover briefing in the control room was excellent.
- Shift 5 appropriately challenged and pursued the proper method for shifting Component Cooling Water pumps.
- Shift 2 had good control of MSIV stroke time and PORV testing.

Completed By: John Hosmer
MOS ObserverDate: 11/01/88Reviewed By: *[Signature]*
Operations Superintendent-NuclearDate: 11/2/88Management
Review By:

<u><i>[Signature]</i></u>	<u>11/2/88</u>	<u><i>[Signature]</i></u>	<u>11/2/88</u>	<u>1</u>	<u>11/01/88</u>
VM-N	Date	SVP	Date	VP	Date

(4)

To: Operations Superintendent - Nuclear

Date: 11/01-02/88

From: John Patterson
(MOS Observer)Shift: ☐ Day
☒ Night

A.. Plant Evolutions Observed

- Unit 3 shutdown, Unit 3 defueled
- Shift turnover/briefing
- Tour of unit 4 containment
- Steam generator eddy current testing

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

Routine shift operations. During the shift briefing, the PSN reviewed operating experience on "voiding in the reactor coolant system." This is a positive step to prevent recurrence of this type of problem.

Completed By: John Patterson
MOS Observer

Date: 11/01-02/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 11/2/88

Management
Review By:

[Signature] 11/2/88 [Signature] 11/2/88
PM-N Date SVP Date VP Date

11/01-02/88

(5)

Date 11/02/88

Shift Report

Shift Mids

Shift Management

P Schimkus APSN Dallau/Singer NWE Matuszewski

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

On 10/30/88 (Sunday Peakshift, PSN (Schimkus) wrote a shift report concerning an effort to return unit 3 PORVs to operable status. The PSN set-up initial priority at the beginning of the shift as stated. The order of events was questioned in regards to Technical Specifications and a required 2.2 sq. in. Reactor Coolant System (RCS) opening. The question was if Technical Specifications may not clearly cover off-normal safety conditions and considerations. The PSN allowed continued work, and pursued help from licensing personnel pointed out that the shift directors concerns may have valid reasoning although the requirements of current Tech. Specs. and ADM-021 would be met with the PSN's original game plan. The PSN accepted recommendations, pursued a new alternative and work progressed. Decisions for this entire shift evolution were made solely by the PSN based on plant personnel recommendations.
(Update to 88-2923 and 88-2925)

C. Good Practices/Professionalism Observed

Shift Director (Mike Crisler) has been exceptional in keeping myself updated on plant status outage work. He has worked many hours of graveyard backshift and his performance is even more exceptional in light of these scheduled work hours.

①

viewed By

APSN

Date

11/4/88

To: Operations Superintendent - Nuclear

Date: 11/02/88

From: John Hosmer

Shift: ☒ Day
☐ Night

(MOS Observer)

A. Plant Evolutions Observed

- Unit 3 in mode 5 filling and venting
- Unit 4 defueled
- 7-8 A.M. control room turnover
- Unit 3 Reactor Coolant System (RCS) fill and vent thru start Reactor Coolant Pump (RCP) 3A
- Portions of control room Heating Ventilation Air Conditioning (HVAC) monthly surveillance
- Tour of unit 4 containment 2:30 - 4:30
- Some of unit 4 spent fuel pool shuffle of fuel from control room
- 6 A.M. and 2 P.M. status meetings

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

On tour of unit 4 containment (2:30 - 4:30), discovered on one Reactor Coolant Pump (RCP) with removed motor, one flanged piping connection was without plastic protective cover i.e., flange and piping internals exposed directly to containment. All other RCPs with motors removed and associated piping disconnected had all flanges protected.

(88-2962) *Closed - 11/07/88*

E. Professionalism, Summary of Shift, Comments

The unit 3 SRO displayed excellent procedural compliance and control of RCS fill and vent. The PSN provided good direction and overview when required, and ensured unit 3 SRO could focus his individual attention on the RCS fill and vent evolution. Communication to the control room concerning the Justification for Continued Operation (JCO) associated with PORVs (eg. rack RCP breakers in and out) was adequate.

Completed By: John Hosmer
MOS Observer

Date: 11/02/88

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

Date: 11/4/88

Management
Review By:

[Signature] 11/3/88 *[Signature]* 11/3/88 *[Signature]* 11/3/88
PM-N Date SVR Date VP Date

11/02/88

To: Operations Superintendent - Nuclear

Date: 11/02-03/88

From: John Patterson
(MOS Observer)Shift: ☐ Day
☒ Night

A. Plant Evolutions Observed

- Unit 3 shutdown, Unit 4 defueled
- Shift turnover/briefing
- Tour of Radiation Control Area (RCA)
- Tour of unit 4 containment
- Steam Generator Eddy current testing
- Tour of intake structure

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

In the unit 4 containment, there were a few cases of workers not having their anti-contamination clothing zipped completely up. Improper use of coveralls can lead to unnecessary contaminations.
(88-2956, additional information)

E. Professionalism, Summary of Shift, Comments

Routine shift operations.

(12)

Completed By: John Patterson
MOS Observer

Date: 11/02-03/88

Reviewed By: Ru P. P. P.
Operations Superintendent - Nuclear

Date: 11/4/88

Management
Review By:

PMN 11/3/88 SVP 11/3/88 VP 11/3/88
Date Date Date

11/02-03/88

Date 11/03/88

Shift Report

Shift Mids

Shift Management

PSN Anderson APSN Dallau NWE Spence

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed:

Everyone on peak shift did a great job with no errors considering the amount of work accomplished; three Emergency Diesel Generators (EDG) tests, starting an Reactor Cooling Pump (RCP), starting the 3A Intake Cooling Water (ICW) pumps test, starting the unit 3 sequencer test, cross-tying the L.C.s on unit 4, Component Cooling Water (CCW) walkdown, and many clearances. A good job done for all.

①

Reviewed By SWP

Date 11/4/88

ONSHIFT OVERSIGHT PROGRAM
DAILY REPORT

Page

1

Date: 11/03/88

John Hosmer
(Observer)

Shift:

Day

A. Plant Evolutions Observed

- Unit 3 in mode 5
- Unit 4 defueled
- 6 A.M. outage briefing
- Meeting with Arias, Pierce and Schimkus. Needed to clarify Technical Specification interpretation memo provided on peak shift
- Diesel 3A 30 day surveillance
- 2 P.M. outage briefing
- Plant tour with emphasis on void excavation
- Read operator standards of professionalism

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

1. Common systems and nonstandard Technical Specifications (TS) have resulted in the need for written TS clarifications. The 11/02/88 TS clarification memo caused confusion on the peak shift. This confusion was resolved by the referenced meeting and an 11/03/88 further clarification letter from Pierce and Arias. Other written communication to the control room in the last 3 - 4 days has also caused some initial confusion.

Recommendation: Have on-shift PSN review all written communication to the control room (give it a users test) prior to formal issuance of the memo.
(88-2978)

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

Date: 11/4/88

3

Management
Review By:

KC 11/4/88 *AC* 11/4/88 *VP*
PM-N Date SAP Date VP Date

DAILY REPORT

Page

Date 11/03/88

Name: Hosmer

Continuation Page

2. Attached PWO was assigned by Operations to the wrong maintenance organization, I&C. The solenoid valve in question is a Target Rock valve which requires mechanical maintenance for leak resolution. Three operators interviewed did not realize this subtle difference. Maintenance planning did not pick this up and time was lost.

Recommendation: Define in some appropriate procedure or data base that Target Rock solenoids require Mechanical Maintenance as the lead versus I&C. (See attached).
(88-2979)

E. Professionalism, Summary of Shift, Comments

Two excellent examples of good practice are as follows:

1. NWO informed a non-operations person requesting permission (and pushing hard) to operate valves, that this was totally unacceptable and would not be allowed and to back off.
2. NO informed the PSN that waste gas decay tank inerting procedures really could not be used as written (yet it had been used as is for a long time). The PSN immediately called on-shift PUP and initiated required procedure change.

4

HD185Q GENERATION EQUIPMENT MANAGEMENT SYSTEM 11/83/88 08.29.42

NUCLEAR WORK REQUEST PLANNING DETAIL (1 OF 6)

WORK REQ NUMBER: WA881102123128 ORIGINATION DATE/TIME: 110288 / 1231

PLANT: PTN UNIT: 03 SYSTEM: 041 ORIG. NAME/DEPT: A M SINGER / 4

LEAD MAINT DEPT(1,2,3): 2 REQ. PRI: 03 UNIT COND. REQD: 5

COMPONENT TAG#: SV-3-6320A ASSOC COMP:

DESC. : PRESSURIZER/REACTOR HEAD VENT DISCHARGE SOLENOID VALVE

PLANT LOCATION: CNTMT 58 FT EL ADJACENT TO PRESSURIZER CUBICLE

DEFECT/REQUEST: VLV LEAKS DURING TESTING AS PER FILL AND VENT PROCEDURE-

SERIOUS/REASON: RCS HEAD VENT VLV LEAKING

DEFICIENCY TAG#: CWA

TRouble/BREaKDOWN: YES LCO REQUIRED: YES

STATUS: (APPROVED)

REWORK JOB: N IF YES, WHY?:

FAILURE DATE: 110288 TIME: 1231 STATUS: A SYMPTOM: E DETECTION: C

==NPRDS ITEM == : (YES) DEFICIENCY TAG LOCATION: ON VPA

HOLD DATES : 0 : 0

SUPERVISOR OR NPS APPROVAL: A M SINGER

HOLD STATUS: :

CANCELED:

REASON FOR CANCELLATION:

DEPRESS THE PF5 KEY TO PAGE FORWARD PF4 KEY ... TO PAGE BACKWARDS
PF6 KEY TO RETURN
ENTER KEY.... TO PROCESS TRANSACTION

(5)

Date: 11/03-04/88

SHIFT OVERSIGHT PROGRAM
DAILY REPORT

Page

1

John Patterson

(Observer)

Shift:

Night

A. Plant Evolutions Observed

- Unit 3 shutdown, Unit 4 defueled
- Shift turnover/briefing
- Tour of Radiation Control Area (RCA)
- Tour of unit 3 containment
- Tour of intake structure
- OSP-023.1 Diesel Generator Operability Test, "B" Emergency Diesel Generator (EDG)

B. Immediate Safety Problems

None

C. Questionable Work Practices

None

D. Areas for Improvement

None

E. Professionalism, Summary of Shift, Comments

During his rounds of the unit 3 containment, the Health Physics (HP) technician picked up trash and debris that littered the containment floors. It would be great if all employees felt this type of pride and ownership in Turkey Point.

(6)

Completed By: John Patterson
Observer

Date: 11/03/88

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

Date: 11/4/88

Management
Review By:

[Signature] 11/4/88 *[Signature]* 11/4/88 *[Signature]* 11/4/88
PM-N Date SWP Date VP Date
11/03/88