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 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251

AUTH. NAME: WOODY, C.O. AUTHOR AFFILIATION: Florida Power & Light Co.
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SUBJECT: Responds to violations noted in Insp Repts 50-250/87-43 & 50-251/87-43.

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DECEMBER 14 1987

L-87-511

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Gentlemen:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Inspection Report 87-43

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

Very truly yours,


D.C. O. Woody
for Executive Vice President

COW/SDF/gp

Attachment

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

SDF/IR.004

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ATTACHMENT

RE: TURKEY POINT UNITS 3 AND 4
DOCKET NO. 50-250, 50-251
IE INSPECTION REPORT 250-87-43 & 251-87-43

FINDING A:

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 5, recommends that procedures for abnormal, offnormal, or alarm conditions should contain the meaning of an annunciator, the source of the signal, the immediate operator action and the long-range actions.

Two examples of failure to implement Regulatory Guide 1.33, Appendix A, Item 5, were identified.

FINDING A.i

Off-Normal Operating Procedure 0-ONOP-048, entitled Off Normal Critical Heat Tracing System Temperature, revision dated June 26, 1985, requires, in Section 3.2, that if no degraded insulation or abnormal system operation is discovered, submit a Plant Work Order (PWO) to have Electrical Maintenance check the heat tracing thermostat.

Contrary to the above, on September 28, 1987, in response to a Heat Tracing Trouble alarm annunciator, a Nuclear Operator (NO), at the direction of the Unit 4 Reactor Control Operator (RCO), manipulated the thermostat for heat tracing circuit number 8 and failed to submit a PWO to have electrical maintenance check the heat tracing thermostat.

RESPONSE A.1:

- 1) FPL concurs with the finding.
- 2) The cause of the finding was personnel error. A contributing cause to the finding was a misinterpretation of procedure 0-ONOP-048. Step 3.2.4 requires the operator to "...investigate to determine if cause for high/low temperature is the result of operating conditions..." Step 3.2.5 states that if no degraded insulation or abnormal system operation is discovered, a PWO is to be submitted to

Electrical Maintenance in order to check the heat tracing thermostat. The investigation for the Heat Tracing Trouble Alarm which was performed in accordance with step 3.2.4, discovered that the thermostat for heat tracing circuit 2 was incorrectly set at the maximum temperature position. At this time, the operator did not perceive a need to have the heat tracing thermostat checked, because it was obviously misadjusted and 0-ONOP-048 did not prohibit adjustment of the thermostat by an operator. The thermostat was reset by the operator.

- 3) The subject operators were counselled about the need to comply with procedural instructions as written, and verbatim compliance.
- 4) Procedure 0-ONOP-048 will be enhanced to assure that heat tracing thermostats are adjusted only by Electrical Maintenance personnel.
- 5) a) Full compliance for item 3 above was achieved by October 2, 1987.
b) Full compliance for item 4 above will be achieved by January 29, 1988.

FINDING A.2

Off Normal Operating Procedure 4-ONOP-059.3, entitled Nuclear Instrumentation Malfunction, revision dated April 14, 1987, Section 5.3.1, requires the RCO to transfer the Comparator Channel Defeat Switch to the failed channel when one power range channel fails low during power operation - Mode 1.

Contrary to the above, on October 2, 1987, with Unit 4 in Mode 1, the Unit 4 RCO failed to transfer the Comparator Channel Defeat Switch in response to power range nuclear instrument channel N-44 failure.

RESPONSE A.2:

- 1) FPL concurs with the finding.
- 2) The cause of the finding was personnel error. Upon the failure of channel N-44, the Assistant Plant Supervisor-Nuclear (APSN) assisted the Reactor Control Operator (RCO) by reading the steps of procedure 4-ONOP-059.3 to the RCO. In this instance, the RCO inadvertently failed to perform a portion of step 5.3.1, and did not transfer the comparator defeat switch to the failed channel. Ineffective communication between the APSN and the RCO resulted in the finding.
- 3) Upon the NRC Inspector pointing out that the step was not performed, the RCO promptly transferred the comparator switch to the failed channel. The event was discussed with the involved operators, and the need for using good communications practices when performing similar evolutions was emphasized at the shift debriefing.



- 4) New procedures 3/4-ONOP-59.8 will be written. These procedures will address the off-normal operation of the power range nuclear instrumentation, and will require step-by-step signoffs for actions that remove malfunctioning channels from service.
- 5) a) Full compliance for item 3 above was achieved on October 2, 1987.
b) Full compliance for item 4 above will be achieved by February 29, 1988.

FINDING A.3

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

Administrative Procedure O-ADM-205, entitled Administrative Control of Valves, Locks, and Switches, revision dated August 11, 1987, requires, in Attachment 2, that the A Boric Acid Storage Tank (BAST) recirculation isolation valve, 344, be controlled locked open.

Contrary to the above, on October 3, 1987, valve 344 was found open but not properly locked.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The cause for the finding was personnel error, in that while the locking device was locked, it was not properly installed and therefore it was possible to manipulate the valve.
- 3) Upon identification of the improper locking of the valve, the valve was verified to be in the proper position. The locking device was then installed properly. Additional actions included completion of O-ADM-205, Attachment 2, Table 6, to insure that no other discrepancies existed.
- 4) Although not specifically taken as a corrective action for this event, training brief 209, addressing proper usage of cable padlocks for locked valves, was issued on October 1, 1987. This event was also discussed at subsequent shift turnover meetings so that other operators would gain increased awareness of proper locking techniques.
- 5) a) Full compliance for item 3 above was achieved on October 3, 1987.
b) Full compliance for item 4 above was achieved by October 4, 1987.

