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SUBJECT: Responds to violations noted in Insp Repts 50-250/88-39 & 50-251/88-39.

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P O. Box 14000, Juno Beach, FL 33408-0420

L-89-59
10 CFR 2.201
MARCH 3 1989

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
Reply to Notice of Violation
Inspection Report 88-39

Florida Power & Light Company has reviewed the subject inspection report and pursuant to 10 CFR 2.201 the response is attached.

This reply to Inspection Report 88-39 is being submitted on this date as discussed with the NRC, Region II.

Very truly yours,

W. F. Conway
Senior Vice President - Nuclear

WFC/RHF/gp

Attachment

cc: Stewart D. Ebneter, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

IE01

ATTACHMENT 1
Reply to a Notice of Violation
NRC Inspection Reports Nos. 50-250, 251/88-39

Violation

TS 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 Section 5.1 of ANSI N18.7-1972. ANSI N18.7-1972 , Section 5.1.2 specifies that procedures shall be followed.

a. Administrative Procedure 0103.4, In-Plant Equipment Clearance Orders, revision dated August 26, 1988, specifies the required instructions to obtain, issue and release clearances to ensure safety and protection of plant personnel and equipment.

Contrary to the above, the following examples were identified in which clearances were not properly executed:

On October 15, 1988, MSIV 4B was found partially open during the Unit 4 containment integrity walkdowns. The valve was tagged closed under a clearance.

On November 17, 1988, operators attempted to place MOV-4-750 on its backseat for repacking. The valve would not open electrically from the control room. This was due to an ongoing Plant Change/Modification (PC/M) being implemented for the MOV.

On November 18, 1988, Valve 4-50-324, 4A ICW/CCW Basket Strainer Inlet Valve, was found closed. The valve was tagged open under clearance 4-88-11-022R.

On November 21, 1988, condensate was spilled into the turbine building area, on two occasions, through disassembled valves 4-20-121 and 4-20-221, 3-way valves for 4A and 4B feedwater pump discharge. The clearances listed on the PWOs to work the two valves were inadequate to provide proper isolation for the work being performed.

On November 22, 1988, the discharge valve for the 4A feedwater pump, MOV-4-1420, was found to be fully open with two separate clearance tags on the manual operator of the valve that required the valve to be in the shut position.

On December 2, 1988, during the performance of safeguards testing on Unit 3, the "A" Steam Generator feed bypass valve, FCV-3-479, failed to close when required on an isolation signal. Subsequent licensee investigation found the fuses in the circuit that provided the close signal to the valve pulled out and in a polybag with clearance 3-87-10-101. The clearance was issued and the fuses pulled on November

3, 1987, and had been in that condition since that date. Review of the Clearance Book indicated that the clearance did not exist in the Clearance Book or the index.

b. Operating Procedure (OP)-041.2, Pressurizer Operation, dated December 3, 1988, requires that the pressurizer heaters and/or sprays be used to maintain Reactor Coolant System (RCS) pressure between 330 and 380 psig while heating up the pressurizer.

Contrary to the above, on December 9, 1988, the Unit 3 Reactor Control Operator failed to maintain RCS pressure below 380 psig. The pressure increased until the Overpressure Mitigation System (OMS) setpoint of 400 to 430 psig was reached. This resulted in the 455C, Power Operated Relief Valve (PORV) opening automatically to reduce RCS pressure.

Response to Finding a.

1) FPL concurs with the finding

2) a) The reason for the example which occurred on October 15, 1988 is not known, however, it is believed that an Instrument Air system malfunction after the clearance was issued resulted in the MSIV being partially opened. This cannot be verified because much of the Instrument Air system associated with the MSIV was removed while installing a plant modification.

b) The example which occurred on November 17, 1988, was a result of not identifying all work being performed on the clearance. The clearance was issued to perform an inspection of the valve. Additional work was performed under the same clearance, however, this additional work was not listed on the clearance. The electrical supervisor who authorized the partial release of the clearance knew that the inspection was complete, but was not aware of the additional work being performed under the same clearance. In addition, the supervisor did not walk down the job prior to authorizing release of the clearance.

c) The cause of the example which occurred on November 18, 1988, has not been identified. However, it appears that the valve was repositioned some time after the clearance was issued. The clearance was issued to allow a crawl through of the Intake Cooling Water system. In order to pass through that portion of the system, the valve had to be open.

d) The first condensate spill which occurred on November 21, 1988 was caused by personnel error in that a mechanical foreman did not request a clearance for valves 4-20-121 and -221, but instead relied on three other clearances which were in the vicinity of these valves. The foremen erroneously believed that the three other clearances provided isolation for the work he was to perform. When Operations attempted to raise the level of the Unit 4 Steam Generators with the condensate transfer pump, they verified that the boundaries of the three clearances were isolated, but did not realize that valves 4-20-121 and -221 were disassembled because there was no clearance. The second spill occurred because Operations failed to issue a clearance and isolate valves 4-20-121 and -221 after the first spill.

e) The cause of the example that occurred on November 22, 1988 appears to be personnel error. It appears that the operator who hung both tags and the operators who were responsible for independent verification did not verify that valve MOV-4-1420 was actually closed.

f) The cause of the example that occurred on December 2, 1988, was personnel error in that the Nuclear Watch Engineer responsible for the final review and signoff of the clearance missed the fact that the fuses had not been installed.

3) a) The 4B MSIV was closed by removing the clearance on the Instrument Air system, and restoring air pressure to the actuator.

b) The clearance for valve MOV-4-750 was re-issued and the work on the MOV completed. The clearance was subsequently released and the MOV was satisfactorily tested.

c) The 4A ICW/CCW Basket Strainer Inlet Valve was repositioned to meet the requirements of the clearance.

d) After the second spill, a clearance was issued to isolate valves 4-20-121 and -221.

e) The discharge valve for the 4A feedwater pump was closed.

f) The fuses were re-installed in the "A" Steam Generator feed bypass valve, and the Nuclear Watch Engineer involved was counseled.

4) a) Plant night orders were issued to plant operations in order to 1) emphasize that a single clearance should be used to create a work boundary, and that multiple clearances should not be used to create a work boundary, and 2) require that when removing clearances, the component shall be placed in its normal position, and shall not be released "as is" (thus relying on subsequent system lineups).

b) The Operations Department initiated independent verification of all clearances as a short term action. Based on the results obtained by other corrective actions, this may be relaxed at a later date.

c) Procedure AP 103.4 "In-Plant Clearance Orders" was revised in order to 1) eliminate the rehanging of partial clearances, 2) require that all work being performed under a clearance shall be listed on that clearance and 3) require that a field walkdown be performed when one supervisor is releasing a clearance for another supervisor or foreman.

d) The Operations Department will review procedure O-ADM-031, "Independent Verification" in order to identify any potential deficiencies or opportunities for improvement. Procedure changes and training on those changes will then be accomplished as required.

e) The Operations Department has instituted an event tracking system in order to trend individual and shift performance. The information gathered will be used to identify problem areas, shifts or personnel

that need attention, and to evaluate the effectiveness of corrective actions.

f) FPL will establish a clearance team to evaluate the overall clearance order process and recommend changes to improve the process.

g) The Operations Department will evaluate expanding the requirements for independent verification of system alignments.

h) The Operations Department will evaluate and establish an improved method of maintaining operations cognizance of system status.

5) a) The actions described in 3 above were completed following identification of each example.

b) The action described in 4a above was completed on January 5, 1989.

c) The action described in 4b above was completed on January 4, 1989.

d) The action described in 4c above was completed on January 9, 1989.

e) The action described in 4d above will be completed by May 1, 1989.

f) The action described in 4e above was initiated on January 31, 1989 and is ongoing.

g) The clearance team described in 4f above will be established by March 15, 1989.

h) The action described in 4g above will be completed by April 1, 1989.

i) The action described in 4h above will be completed by June 1, 1989.

Response to Finding b.

1) FPL concurs with the finding.

2) This event resulted from operator inattention to detail.

3) a) RCS pressure was restored within normal operating parameters.

b) The operator involved was counseled.

4) a) An evaluation will be performed to determine if the OMS alarm setpoint can be lowered to provide a greater margin between the alarm setpoint and the actuation setpoint. This evaluation will also consider the possibility of narrowing the operating band to provide further margin between the operating point and the actuation setpoint.

b) While conducting an investigation of this event, deficiencies with the alarm response procedure were identified. Although these deficiencies did not contribute to this event, the procedure will be revised to correct these deficiencies.

c) The Operations Department has instituted an event tracking system in order to trend individual and shift performance. The information gathered will be used to identify problem areas, shifts or personnel that need attention, and to evaluate the effectiveness of corrective actions.

5) a) The action described in 4a above will be completed by May 31, 1989.

b) The action described in 4b above will be completed by March 31, 1989.

c) Implementation of the action described in 4c above was initiated on January 31, 1989 and is on going.