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ACCESSION NBR:8910180333 DOC.DATE: 89/10/12 NOTARIZED: NO DOCKET #
 FACIL:50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 AUTH.NAME AUTHOR AFFILIATION
 POWELL,D.R. Florida Power & Light Co.
 HARRIS,K.N. Florida Power & Light Co.
 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-014-00:on 890912,CCWFR to emergency containment
 coolers below design accident requirement.

W/8 ltr.

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L-89-371
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Units 3 & 4
Docket No. 50-250/251
Reportable Event: 89-14
Date of Event: September 12, 1989
Component Cooling Water Flow Rate to the Emergency Containment Coolers Below
Design Basis Accident Requirement due to Inadequate Administrative Controls

The attached Licensee Event Report is being submitted pursuant to the requirements of 10 CFR 50.73 to provide notification of the subject event.

Very truly yours,

K. N. Harris
Vice President Turkey Point Plant Nuclear

KNH/STD/sem

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

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Turkey Point Unit 3										DOCKET NUMBER (2) 0 5 0 0 0 2 5 0										PAGE (3) 1 OF 0 13	
TITLE (4) Component Cooling Water Flow Rate to the Emergency Containment Coolers below Design Basis Accident Requirement due to Inadequate Administrative Controls																					
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)											
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES						DOCKET NUMBER(S)						
0 9	1 2	8 9	8 9	0 1 1 4	0	0 1	0 1	2 8 9	Turkey Point Unit 4						0 5 0 0 0 2 5 1						
OPERATING MODE (9) 1			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																		
POWER LEVEL (10) 1 1 0 1 0		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)							
		20.406(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)							
		20.406(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)							
		20.406(a)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(vii)(A)											
		20.406(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)											
		20.406(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)											
LICENSEE CONTACT FOR THIS LER (12)																					
NAME David R. Powell - Regulation and Compliance Supervisor										TELEPHONE NUMBER											
										AREA CODE 3 0 1 5		NUMBER 2 1 4 6 - 1 6 5 5 1 9									
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																					
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC											
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR					
<input checked="" type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input type="checkbox"/> NO		1 2	1 5	8 9					
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																					

On September 12, 1989, with Units 3 and 4 in Mode 1 at 100%, the Component Cooling Water (CCW) System Engineer (non-licensed utility personnel) discovered that the mechanical stops for the discharge valves from the Emergency Containment Coolers (ECC) to the CCW System were in positions that may not ensure that each ECC would receive the minimum design CCW flowrate during post-accident conditions. An analysis is being performed to determine the impact this condition may have (if any) on the containment temperature and pressure profiles. A cause of the event was inadequate administrative controls. The mechanical stops of the subject valves were re-adjusted to the settings previously determined by the appropriate special tests. Information tags will be placed on the subject valves identifying the basis for throttling the valves and the correct settings for the mechanical stops.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER						
Turkey Point Unit 3	0 5 0 0 0 2 5 0	8 9	— 0 1 4	— 0 0				0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 368A's) (17)

DESCRIPTION OF EVENT

On September 12, 1989, with Units 3 and 4 in Mode 1 at 100%, the Component Cooling Water (CCW) System Engineer (non-licensed utility personnel) discovered that the mechanical stops for the discharge valves from the Emergency Containment Coolers (ECC) (EIIS: BK) to the CCW System (EIIS: BI) (CV-3/4-2906, 2907, and 2908) were in positions that may not ensure that each ECC would receive the minimum design basis CCW flowrate during post-accident conditions. Sections 6.3 and 9.3 of the Final Safety Analysis Report (FSAR) require that each ECC receives a minimum CCW flowrate of 2000 GPM during post-accident conditions.

In March and April 1986, special tests were performed on Units 3 and 4, respectively, to properly balance the CCW system flows to safety related components thereby ensuring flows to the components were within their design requirements. The mechanical stops for the subject valves were adjusted to ensure a minimum CCW System flowrate of 2000 GPM to each ECC during post-accident conditions.

In January 1989, procedure changes to Surveillance Procedures 3/4-OSP-055.1, "Emergency Containment Cooler Operability Test," were approved to change the acceptance criteria on the CCW flows to the ECCs from "2000 GPM or greater" to "2000 GPM to 3040 GPM." These changes were made to address erosion concerns involving the CCW heat exchanger tubes as a result of a concern raised by a member of the Management on Shift Program.

In April 1989, surveillance procedures 3/4-OSP-055.1 were performed as required by administrative procedure, O-ADM-021, "Technical Specification Implementation Procedure." The CCW System flowrates to the ECCs were found to exceed the 3040 GPM limit. Due to this, the mechanical stops of CV-3/4-2906, 2907, and 2908 were re-adjusted, reducing the CCW System flowrate to each ECC. On September 12, 1989, during a further review of system performance criteria, the CCW System Engineer (non-licensed utility personnel) determined that these re-adjustments may not ensure that each ECC would receive the design basis CCW System flowrate for post-accident conditions.

After identification of this concern, the mechanical stops for CV-3-2906, 2907, and 2908 were adjusted to the settings provided by the appropriate special test. This ensured that each ECC would receive the minimum design basis CCW flowrate during post-accident conditions.

At 1911, on September 12, 1989, Unit 4 was placed in Technical Specification 3.0.1 due to an evaluation that the CCW flows to the ECCs may be outside the design basis for post-accident conditions. Since the Technical Specification Surveillance criteria for the ECCs was met, the operability of the Unit 3 ECCs was not initially questioned. The possibility of the CCW flowrates to the ECCs being outside the design basis was addressed after the mechanical stops to the Unit 3 discharge valves from the ECCs to the CCW System were returned to the positions verified in the appropriate special test, and a review of the Unit 4

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Turkey Point Unit 3	05000250	89	014	00	03	OF	03

TEXT (If more space is required, use additional NRC Form 366A's) (17)

ECCs occurred. At 2007, on September 12, 1989, the NRC Operations Center was notified by a one hour significant event report in accordance with 10CFR50.72 (b)(1)(i)(B) of this potential problem. The mechanical stops to CV-4-2906, 2907, and 2908 were adjusted to the settings identified in the appropriate special test. The Unit 4 ECCs were then returned to service. At 2055, on September 12, 1989, the NRC Operations Center was notified that Unit 4 was no longer in Technical Specification 3.0.1.

CAUSE OF EVENT

A cause of the event was inadequate administrative controls. After completion of the special tests in March and April 1986, adequate controls were not in place to prevent adjustment of the mechanical stops on the discharge valves from the ECCs to the CCW System. Further investigation into the cause of this event is ongoing. The results of this investigation will be included in a supplemental Licensee Event Report.

ANALYSIS OF EVENT

An analysis is being performed to determine the impact this condition may have posed. The results of this analysis will be included in a supplemental Licensee Event Report.

CORRECTIVE ACTIONS

- 1) The mechanical stops to the discharge valves from the ECCs to the CCW System were adjusted to the settings previously verified in the appropriate special tests to ensure that each ECC would receive the required CCW flowrate for the post-accident conditions.
- 2) Permanent information tags will be placed on the subject valves identifying why they are throttled, and the correct settings for the mechanical stops. Temporary tags have been placed on the subject valves stating that the mechanical stops are not to be manipulated. Placement of permanent tags will be completed by October 24, 1989.

ADDITIONAL INFORMATION

Licensee Event Report 50-250-86-009-0 identifies a similar incident.