

FEBRUARY, 16 1990

L-90-65
10 CFR 2.201

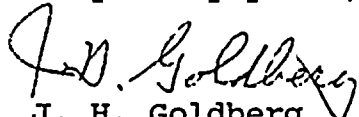
U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Gentlemen:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Reply to Notice of Violation
Inspection Report 89-52

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

Very truly yours,



J. H. Goldberg
Executive Vice President
Nuclear Energy

JHG/GRM/slh

Attachment

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

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ATTACHMENT

RE: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
NRC Inspection Report 89-52

FINDING

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 Appendix A of USNRC Regulatory Guide 1.33 and Sections 5.1 and 5.3 of ANSI N18.7-1972. Section 5.1 of ANSI N18.7-1972 requires that procedures be followed.

1. Operating Procedure (OP) 5163.2, Waste Disposal System - Controlled Liquid Release to the Circulating Water, dated November 9, 1989, Section 8.2, Controlled Liquid Release from The Radwaste Building Waste Monitor Tanks (WMT), provides directions for the release of liquids from the WMT. A Liquid Release Permit (LRP) had been authorized for the B WMT.

Contrary to the above, on December 18, 1989, a liquid release was performed per OP 5163.2, Section 8.1, in lieu of Section 8.2, resulting in the inadvertent release of the B Monitor Tank liquid waste for which no LRP had been issued.

2. Surveillance Procedure 0-OSP-023.1, Diesel Generator Operability Test, dated June 22, 1989, Section 7.2.21, requires the operator to set the governor speed droop control to 30 on the droop scale.

Contrary to the above, on December 21, 1989, during performance of 0-OSP-023.1, the inspectors noted the speed droop was set to zero instead of 30. While setting the droop, the test was invalidated; therefore, retesting was required.

RESPONSE TO EXAMPLE 1

1. FPL concurs with the finding.
2. The inadvertent release of the B Monitor Tank liquid waste instead of the B Waste Monitor Tank was personnel error. The Nuclear Operator (NO) made a log entry that the B Waste Monitor Tank was to be released. However, the NO had earlier observed that the B Monitor Tank was on recirculation. Since liquid waste tanks are normally placed on recirculation prior to release, the NO upon being notified that the B Waste

Monitor Tank was to be released, inadvertently went to the B Monitor Tank section of procedure OP 5163.2, "Waste Disposal System - Controlled Liquid Release to the Circulating Water," which resulted in the release of the B Monitor Tank.

Contributing factors were the similarity in names of the two tanks along with the NO previously observing the B Monitor Tank on recirculation. Additionally, the procedure did not require an independent verification of the tank to be released against the Liquid Release Permit.

3. Corrective steps which have been taken and the results achieved:
 - a. The responsible operator was disciplined.
 - b. This incident was recorded in the night order book to inform all operations personnel.
 - c. Procedures OP 5163.2, "Waste Disposal System - Controlled Liquid Release To The Circulating Water, " and OP 5523.1, "Waste Disposal System - Gas Decay Tank, Controlled Release To Atmosphere," have each been revised to include an independent verification to validate the tank to be released against the appropriate Release Permit.
 - d. The Liquid Release Permit form was modified by replacing the "tank" entry portion of the form with check boxes for each tank. The Gas Release Permit was reviewed and no changes were deemed necessary.
4. The date when full compliance will be achieved:
 - a. Item 3.a. was completed on December 24, 1989.
 - b. Item 3.b. was completed on December 21, 1989.
 - c. Item 3.c. was completed on December 19, 1989.
 - d. Item 3.d. was completed on January 29, 1990.

RESPONSE TO EXAMPLE 2

1. FPL concurs with the finding.
2. The B Emergency Diesel Generator (EDG) governor speed droop control was not set to 30 as required in procedure O-OSP-023.1. Due to poor communications and an inadequate pre-job briefing, the Senior Nuclear Plant Operator (SNPO) believed step 7.2.21 to be a Reactor Control Operator (RCO) performed step. The RCO in the Control Room observed the frequency

decreasing from 60.4 Hertz (Hz) to 59.9 Hz and assumed that the SNPO located at the B EDG had set the droop control to 30. Responsibility for performing specific procedural steps and points of communication were not covered in the pre-job briefing.

3. Corrective steps which have been taken and the results achieved:

- a. The B EDG was successfully retested.
- b. The operators involved were counselled on this event by the shift supervisor. The need for thorough pre-job briefings and better communications was emphasized.
- c. Information explaining this occurrence was provided to operations personnel in the night order book.
- d. Procedure 0-OSP-023.1 was modified to incorporate steps which require the SNPO to notify the RCO when the EDG governor speed droop is set to 30.

4. The date when full compliance will be achieved:

- a. Item 3.a. was completed on December 21, 1989.
- b. Item 3.b. was completed on December 21, 1989.
- c. Item 3.c. was completed on December 21, 1989.
- d. Item 3.d. was completed on December 21, 1989.

