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 FACIL:50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251

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 GOLDBERG, J.H. Florida Power & Light Co.
 RECIP.NAME RECIPIENT AFFILIATION
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SUBJECT: Responds to notice of violation from Insp Repts 50-250/89-54
 & 50-251/89-54.

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MARCH 14 1990

L-90-99
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 89-54

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/sh

Attachment

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

9003220267 900314
PDR ADCK 05000250
Q PDC

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RE: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
NRC Inspection Report 89-54

FINDING 50-250,251/89-54-01

10 CFR 50, Appendix B, Criterion XV, as implemented by the approved Florida Power and Light Topical Quality Assurance Report (FPLTQAR) 1-76A, Revision 13, Topical Quality Requirement (TQR) 15.0, Revision 6, required that nonconforming items be reviewed and accepted, rejected, repaired or reworked in accordance with documented procedures. Furthermore, measures must be established to control materials, parts, or components which do not conform to requirements in order to prevent their inadvertent use or installation. Quality Procedure (QP) 15.2, Revision 3, required the cognizant QC organization to review and document that specified corrective actions contained in NCRs are completed. QP 15.2 also required that items identified as discrepant be controlled to ensure the items are not inadvertently installed or operated.

Contrary to the above, site QC documented closure of NCR 86-421 on May 2, 1988, without properly verifying that defective Peerless-Winsmith Motor Operated Valve (MOV) DC Motors were returned to the vendor for lead wire repair. Additionally, two spare motors remained in the warehouse without adequate controls to preclude inadvertent use.

RESPONSE

1. ADMISSION OR DENIAL OF THE VIOLATION:

FPL concurs with the finding.

2. THE REASON FOR THE VIOLATION:

The cause of this event was determined to be inadequate procedural guidance and inadequate communications. The individual signing for the QC verification accepted verbal communication, as allowed by procedures in effect at the time, from Electrical Maintenance that the subject motors had been shipped off site to the vendor; however, they had not been shipped at that time. Prior to actually preparing the motors for shipment, the electricians examined them for the suspect motor leads. Since two of the three motors did not have the suspect Nomex Kapton motor leads, the electricians determined the motors did not need to be returned to the vendor. The one motor that had the suspect leads was stripped of its quality documentation and given to training as a training aid. The other two that did not have the suspect motor leads were left in storage. QC was not notified that the motors had not actually been shipped off site which was the original corrective action requirement for the NCR.

As a result of a review of records of the 1988 event, FPL was unable to confirm whether or not QC hold tags had been placed on the motors when the problem with the suspect motor leads was first discovered. If the QC tags had been installed, their presence would have required QC approval before the motors were released.

3. THE CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED:

- a. The three suspect motors were located on site. One was being used by training as a training aid. The QC documentation had been removed from the latter motor precluding its use in the plant. QC hold tags were placed on the other two (2) motors to preclude their inadvertent use. In January, 1990, both motors were verified to not have Nomex Kapton motor leads. Nomex Kapton heater leads were found on one (1) of the two (2) motors. The heater leads were removed since the ambient temperatures at this site do not require use of the heaters.
- b. Following the inspection, the hold tags were removed and both motors were returned to the ready spare status.
- c. Current procedure QI 15-PTN-1, "Nonconforming Materials, Parts, or Components" requires tagging of suspect items in accordance with QI 14-PTN-1, "Inspection, Test, and Operating Status," to preclude inadvertent installation and use.

4. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS:

- a. On April 10, 1989, Turkey Point Plant Quality Instruction, QI 15-PTN-1 was issued which provided a clearer definition of the verification necessary to close a non-conformance report.
- b. This event and the revised procedure have been reviewed with all applicable QC personnel to emphasize the importance of full documentation for closure of NCRs.

5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

- a. Corrective action 4.a. was completed April 10, 1989.
- b. Corrective action 4.b. was completed on February 23, 1990.

FINDING 50-250,251/89-54-02

10 CFR 50, Appendix B, Criterion XVI, as implemented by the approved FPLTQAR 1-76A, revision 15, TQR 16.0, Revision 5, required that in the case of significant conditions adverse to quality, the cause of the condition shall be determined and action taken to preclude repetition. QP 16.1, Revision 9, required each organization establish a system to follow-up and assure completion of corrective action resulting from their respective department's audits, inspections, surveillances, tests or operations. QP 2.17, Revision 1, required the cause of failure for any Environmental Qualification (EQ) component be documented, and it needed to be determined if the cause was related to a service environment failure mode or not. Additionally, EQ DOC Pac 13.1 specified the life of the EB25 terminal boards as being 40 years in its service environment.

Contrary to the above, terminal block corrosion was identified on the Unit 3 MSIV platform in November 1988 on NCR 88-214. The corroded terminal blocks were replaced and the corrosion was analyzed by an offsite laboratory as specified in the NCR disposition. However, no actions to prevent recurrence were taken. Subsequently, Unit 4 experienced a reactor trip on December 23, 1989, which was caused by the 4A MSIV closing. The closure of the 4A MSIV was attributed to terminal block corrosion leading to a short circuit between contacts, blowing a control power fuse. Additionally, the 40-year specified life of the terminal blocks was not met since the boards were installed for approximately one year before failure.

RESPONSE

1. ADMISSION OR DENIAL OF THE VIOLATION:

FPL concurs with the finding.

2. THE REASON FOR THE VIOLATION:

The problem resulted from inadequate corrective actions taken to resolve NCR C-0214-88. This was caused by a non-cognitive personnel error and deficiencies in procedures which govern the processing of NCRs. NCR C-0214-88 was written to resolve a problem involving over-pressurization of solenoid valves. This problem was unrelated to the corrosion of the terminal blocks. The corroded terminal blocks were subsequently added to NCR C-0214-88 to resolve this discrepancy. As a result, the solenoids and terminal blocks were replaced. The corroded terminal blocks were then sent to the vendor for analysis. The analysis was subsequently received from the vendor and forwarded to JPN but no action was taken at this time because the original NCR had been closed. Long term resolution of the terminal block problem was overshadowed by the corrective actions associated with



the solenoid and terminal block replacement. The NCR was not returned to Nuclear Power Plant Engineering (JPN), because the NCR continuation sheet entry for "Return to JPN" was checked "No" and the disposition was identified as a "Final Disposition" once the solenoids and terminal blocks were replaced. JPN did not have a specific tracking system to track the recommended follow-up vendor analysis outside of the NCR.

The December 23, 1989, failure of the terminal block was examined during the root cause investigation completed by JPN on February 14, 1990. Licensee Event Report 250-89-020 provides additional information on this failure.

3. CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED:

- a. Administrative Site Procedure (ASP-8), "Corrective Action" governing corrective action for construction activities has been revised to require Construction QC to verify that JPN performs a root cause evaluation of any failed equipment or component that they identify as environmentally qualified under 10 CFR 50.49. This verification is to be performed prior to closure of the affiliated NCR.
- b. An additional action note has been added to the construction NCR status sheet/checklist which acts as a reminder to both JPN and construction Quality Control that a root cause evaluation is required for EQ equipment.

4. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS:

- a. Training of applicable construction personnel will be performed to ensure better interpretation and a more precise extraction of corrective action instructions from NCRs.
- b. JPN will revise the existing NCR mainframe computer database tracking system to include and track any follow-up JPN action items (ie. reports, root cause analysis, etc.).

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5. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

- a. Corrective action 3.a. was completed in February, 1990.
- b. Corrective action 3.b. was completed in February, 1990.
- c. Corrective action 4.a. will be completed by April 2, 1990.
- d. Corrective action 4.b. will be completed by April 30, 1990.