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 FACIL:50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
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 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 90-009-00:on 900710,action requirement of Tech Spec
 3.3.1 re containment air lock pressure test was not met.
 W/9 ltr.

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L-90-317
10 CFR 50.73

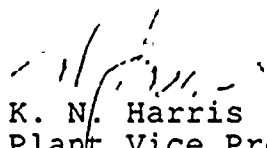
U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
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Gentlemen:

Re: Turkey Point Unit 4
Docket No. 50-251
Reportable Event: 90-009-00
Date of Event: July 12, 1990
Containment Personnel Air Lock Pressure Test Not
Performed in Accordance With Plant Technical
Specifications Due To Work Control Deficiencies

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
Plant Vice President
Turkey Point Plant Nuclear

KNH/DPS/ds

attachment

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 4										DOCKET NUMBER (2) 0 5 0 0 0 2 5 1										PAGE 15 1 OF 4						
TITLE (4) Containment Personnel Air Lock Pressure Test Not Performed In Accordance With Plant Technical Specifications Due To Work Control Deficiencies																										
EVENT DATE (6)			LER NUMBER (3)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)																
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES						DOCKET NUMBER(S)											
0	7	1	0	9	0	9	0	—	0	0	9	—	0	0	0	9	2	0	9	0	0 5 0 0 0 0					
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																								
1		20.402(b)				20.406(e)				80.73(a)(2)(iv)				73.71(b)												
POWER LEVEL (10)		20.406(a)(1)(i)				80.36(a)(1)				80.73(a)(2)(v)				73.71(e)												
11010		20.406(a)(1)(iv)				80.36(a)(2)				80.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 368A)												
		20.406(a)(1)(w)				X 80.73(a)(2)(ii)				80.73(a)(2)(vii)(A)																
		20.406(a)(1)(v)				80.73(a)(2)(iii)				80.73(a)(2)(vii)(B)																
		20.406(a)(1)(v)				80.73(a)(2)(iv)				80.73(a)(2)(ix)																
LICENSEE CONTACT FOR THIS LER (12)																										
NAME										TELEPHONE NUMBER																
D. R. Powell, Superintendent of Licensing										AREA CODE		3 0 5 2 4 6 - 6 5 5 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										
YES (If yes, complete EXPECTED SUBMISSION DATE)										X NO																

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On July 10, 1990, with Unit 4 in Mode 1 (Power Operation), at approximately 100 percent power, the Action requirement of Technical Specification (TS) 3.3.1 was not met. Corrective maintenance performed on the personnel air lock inner equalizing valve on July 10 made the inner barrier of the air lock technically inoperable until a full pressure test could be performed. With the outer door inoperable due to a failed surveillance test and the inner barrier technically inoperable, the Action requirement of TS 3.3.1 was not met. In addition, TS 3.3.4 requires a full pressure test within 24 hours and prior to declaring the air lock operable. Therefore, the personnel air lock Limiting Condition for Operation (LCO) was not met from July 11, 1990, until a full pressure test was performed on August 7, 1990. To prevent recurrence, work orders issued on the personnel and emergency air locks will be printed with a caution statement. The caution states that, during time when the air lock is required to be operable and maintenance is required on one barrier (door, valve, etc.), no maintenance shall be performed on the other "operable" barrier. In addition the event was reviewed with applicable personnel to emphasize the post-maintenance test requirements.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use addendum NRC Form 364A-1 (1/77))

I. EVENT DESCRIPTION

On July 9, 1990, the outer door of the Unit 4 Personnel Access Hatch did not meet the acceptance criteria specified in procedure 4-OSP-051.6, "Containment Air Lock Doors Operability Test." Strong backs were installed on the inner door to meet the Technical Specification (TS) 3.3.4 requirement to lock the inner door closed. A work request was initiated to effect repairs.

On July 10, 1990, a plant worker, while performing an inspection of interlocks and adjustable rods, observed the packing of the containment to air lock equalizing valve to be loose. The worker, seeing something wrong that he was qualified to fix, corrected the problem by adjusting the packing. This was within the scope of the work order. He reported the adjustment in the work order description of work done as required by the work order. The adjustment of this packing made the barrier between the air lock and containment inoperable until a full pressure test could be performed satisfactorily. Since the outer personnel air lock door was inoperable for maintenance at this time, the technical inoperability of the inner barrier made the air lock inoperable.

The outer hatch door was open. The equalizing valve to containment was technically inoperable. The full pressure test required to make the containment equalizing valve operable was not performed until August 7. Therefore, the time allowed by the Action statement of TS 3.3.1 "Containment Integrity" to restore containment integrity was exceeded. On July 11, 1990, the time allowed by TS 3.3.4 "Containment Air Locks" Action b, to restore the air lock to operability, was exceeded.

On July 11, 1990, upon successful completion of 4-OSP-051.6, the air lock was declared operable and returned to service even though it was still technically inoperable.

On July 12, 1990, verbal communications between Technical Department and Maintenance personnel indicated that the work performed on July 10 and 11, 1990, consisted entirely of work on the interlocks and adjustable rods. Based on this information, a full pressure test was not required. Successful completion of procedure 4-OSP-051.6 was determined to be the only requirement for declaring the air lock operable.

On August 7, 1990, a full pressure test (required as a six month surveillance) was successfully performed on the Unit 4 personnel hatch. A work request was initiated to correct a small amount of leakage (within allowable limits) that was noted during the test. On August 8, during the work planning meeting for that work request, personnel noted that the work performed on July 10 and 11, may have been more extensive than reported in the July 12 verbal communications. The work package for the work performed on July 9 and 10 was in the review process and was, on August 22, found on the desk of a reviewer that had been on vacation.

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TEXT (If more space is required, use additional NRC Form 364A's) (17)

On August 15, 1990, following the maintenance to correct the leakage noted above, a full pressure test was again performed successfully.

On August 22, 1990, a review of the applicable work order package showed that in accordance with TS 4.4.2 2.b., this repair work required a full pressure test prior to declaring the air lock operable.

Thus the personnel air lock was technically inoperable from July 9, 1990, until August 7, 1990. The Action requirements of Technical Specification 3.3.4 Action a were met until the locking device was removed on July 11, 1990. The Action requirements of Technical Specification 3.3.4 Action b were met until the 24 hour time requirement of Action b was exceeded on July 11, 1990. The one hour time requirement of the Action statement of TS 3.3.1 was exceeded on July 10, 1990.

II. EVENT CAUSE

The cause of the event was a work control deficiency in that no controls were in place to prevent maintenance from working on the inner barrier while the outer barrier was inoperable. Inadequate communications between maintenance and technical personnel contributed to this event. The verbal information received indicated that no maintenance requiring a full pressure test had been performed on July 10 and 11, 1990.

III. EVENT SAFETY ANALYSIS

The safety function operability question raised by this event was the capability of the personnel air lock to prevent the inadvertent release of radioactive fission fragments (third barrier - containment integrity) from July 9, 1990 till August 7, 1990. The full pressure test was successfully completed on August 7, 1990. This test demonstrated that the personnel air lock was capable of meeting its intended safety function. This test also provides a reasonable assurance that the personnel air lock was capable of performing its intended safety function during the time of this event, (July 9, 1990, through August 7, 1990). Thus the health and safety of the public were not affected by this event.

IV. CORRECTIVE ACTIONS

- A. The computer program that generates work orders has been updated to print a caution statement on work orders for the personnel and emergency air locks warning that during time when the air lock is required to be operable and maintenance is required on one barrier (door, valve, etc.), that no maintenance shall be performed on the other "operable" barrier.

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

TEXT (If more space is required, use addendum NRC Form 308A's (17))

- B. The event was reviewed with Mechanical Maintenance Foremen and Supervisors to emphasize the safety functions of the airlocks and their associated hatches and the post-maintenance test requirements that are used to verify that these safety functions are functional.

V. ADDITIONAL INFORMATION

A. Similar Events

A similar event was reported in LER 250-90-002, "Post-Maintenance Test Not Performed to Establish Operability of a Phase A Containment Isolation Valve After Adjusting the Valve Stem Packing Due to Personnel Error."

Another similar event was reported in LER 251-89-007, "Missed Visual Examination on Repaired Containment Penetrations Due To Personnel Error."

B. Equipment Failures

None

C. Existing Program Features

Mechanical maintenance personnel are taught, as a standard practice, to report any equipment or components observed that need attention (corrective maintenance, inspection, etc.). This standard practice is designed to prevent work outside the scope of issued Plant Work Orders.

