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Document Control Branch (Document Control Desk)

SUBJECT: Forwards response to NRC ltr re violations noted in insp repts 50-250/96-13 & 50-251/96-13 on 961117-1231.Corrective actions:non-licensed operator involved in event was counseled on need for compliance to procedures.

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Florida Power & Light Company, P.O. Box 14000, Juno Beach, FL 33408-0420

FPL

FEB 28 1997

L-97-043
10 CFR 2.201

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

Re: Turkey Point Units 3 & 4
Docket Nos. 50-250/251
Reply to Notice of Violation
NRC Inspection Report 96-13

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

If there are any questions, please contact us.

Very truly yours,

T. F. Plunkett
President
Nuclear Division

CLM

Attachment

cc: Luis A. Reyes, Regional Administrator, Region II, USNRC
T. P. Johnson, Senior Resident Inspector, USNRC, Turkey Point Plant

110058

REPLY TO NOTICE OF VIOLATION

RE: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
NRC Inspection Report 96-13

FINDING

"During an NRC inspection conducted on November 17 to December 31, 1996, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," NUREG 1600, the violation is listed below:

Technical Specification 6.8.1 requires that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Item 7.a of Regulatory Guide 1.33, Revision 2, February 1978, Appendix A, recommends the use of procedures for activities involving the liquid radwaste disposal system.

Procedure 0-OP-061.12 Waste Disposal System-Waste Monitor Tank (WMT) and Demineralizer Operation, section 5.1, Recirculation and Sampling of the WMTs, requires the non-licensed operator to independently verify the valve lineup prior to WMT recirculation per the appropriate procedure attachment.

Contrary to the above, on December 17, 1996, the non-licensed operator failed to adequately implement section 5.1 of procedure 0-OP-061.12, as the valve lineup independent verification was not performed as documented on the appropriate procedure document. Subsequently, during B WMT recirculation, an overflow and spill of the A WMT occurred.

This is a Severity Level IV violation (Supplement I)."

RESPONSE TO FINDING

1. Florida Power & Light Company (FPL) concurs with the finding.

2. **Reason for the violation:**

The recirculation of the Waste Monitor Tanks (WMT) for sampling is a routine evolution that is controlled by procedure 0-OP-061.12, Waste Disposal System-Waste Monitor Tanks and Demineralizer Operation. On December 17, 1996, the C WMT was aligned and placed on recirculation for sampling. During this process the B WMT overflowed to the Radwaste Building floor. The most probable cause of this event was a valve misalignment (the misalignment could not be verified) that allowed a transfer of water from the C WMT to the B WMT, when the C WMT was placed on recirculation. The valve misalignment was not found prior to starting the recirculation of C WMT because the Non-licensed Operator performing the task failed to comply with the independent verification requirements of procedure 0-OP-061.12. The procedure requires an independent verification of the valve lineup prior to starting a pump for a recirculation.

The overflow of the A WMT that occurred on February 26, 1996, was due to a valve being left open, instead of closed as required by 0-OP-061.12, when recirculation of the A WMT for sampling was terminated. Due to this misaligned valve, water was inadvertently transferred to the A WMT when the B WMT's contents were being transferred to the A monitor tank (different than the A WMT). The cause of this event was that the Non-licensed Operator failed to complete the requirements of 0-OP-061.12 when the recirculation of the A WMT was completed. When the February 96 event occurred, procedure 0-OP-061.12 did not require independent verification for WMT valve manipulations. The addition of the independent verification requirement was a corrective action for this earlier event.

The overflow of A WMT on February 26, 1996, was due to the Non-licensed Operator not completing the requirements of 0-OP-061.12. When the A WMT recirculation was completed, leaving a normally closed valve open, independent verification of the valve position was not required. The December overflow of the B WMT was due to a most probably mispositioned valve where the Non-licensed Operator failed to comply with the independent verification requirements established as a barrier to prevent a WMT overflow recurrence.

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

The Non-licensed Operator involved in this event was counseled on the need for compliance to procedures, management's expectations on the conduct of tasks, and the professional manner required for work in a nuclear power plant.

A root cause analysis of the tank overflow event was performed. Seven possible scenarios were analyzed. Four were eliminated based primarily on satisfactory tank recirculations before and after the spill; the remaining three all required valve mispositions/repositions to accommodate the known facts of the event.

On-shift supervision has been instructed to observe evolutions involving the movement of radioactive waste water for a two month duration to ensure there are no further procedural compliance concerns or procedure discrepancies. Identified concerns are forwarded to the Operations Supervisor for resolution.

4. **Corrective actions which will be taken to prevent further violations:**

The Operations Supervisor discussed the details of this event and corrective actions with the on-shift Non-licensed Operators.

The Non-licensed Operator involved in this has been permanently reassigned to a position out of the Nuclear Operations Department.

As part of the on-shift supervision's observation of radwaste movements, procedure 0-OP-061.12 is being reviewed to determine if further enhancements would be beneficial.

A radwaste control panel remote alarm has been installed in the Unit 3 & 4 Control Room. Prior to its installation, Operations personnel had been instructed that an Operator be continuously stationed in the area of the WMTs during radioactive waste water transfers or WMT recirculation.

5. **The date when full compliance was or will be achieved:**

Full compliance was achieved on December 17, 1996, with the completion of the valve alignment check by Operations Management, and completion of the required sections of 0-OP-061.12.