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FLORIDA POWER & LIGHT COMPANY

December 20, 1982
L-82-548

Mr. James P. O'Reilly
Regional Administrator, Region II
U. S. Nuclear Regulatory Commission
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250, 50-251
IE Inspection Report 82-30

Florida Power and Light Company has reviewed the subject inspection report and a response is attached.

The area of heat tracing has been substantially upgraded as a result of increased management attention. This was discussed in detail with Region II management in Atlanta on October 28, 1982, as documented in your Inspection Report 50/250/82-35. As a result, the root causes for the heat tracing problems were identified as 1) inadequate priorities assigned by management to the operation and maintenance of heat tracing and 2) inadequate quality of the originally installed heat tracing. In order to remedy this, the following actions have been taken:

1. An in-depth training course on heat tracing was prepared and presented to appropriate operators, quality control personnel and electrical personnel.
2. A maintenance procedure on heat tracing was written and implemented to better control work on heat tracing circuits.
3. The operating procedures on heat tracing were revised to upgrade the periodic test of heat tracing and to provide accurate, current listings and drawings of all the heat tracing circuits.
4. Increased quality control inspections of heat tracing circuit operations and maintenance were initiated.
5. The numbering system of the individual heat tracing circuit breakers was revised to be consistent with the numbering system of the heat tracing circuits.
6. The changeout of the originally installed heat tracing to a new, much improved type has been expedited.

There is no proprietary information in the report.

Very truly yours,

Robert E. Uhrig
Vice President
Advanced Systems and Technology

REU/DWJ/sr
Attachment

cc: Harold F. Reis, Esquire

ATTACHMENT

RE: TURKEY POINT UNITS 3 AND 4
DOCKET NOS. 50-250, 50-251
IE INSPECTION REPORT 82-30

FINDING A:

A. Technical Specification 6.8.1 requires that procedures be implemented. Operating Procedure 2500.1, Heat Tracing System - Normal Operation, prescribes operating procedures for safety related heat tracing.

Contrary to the above, Step 8.2 of Operating Procedure 2500.1, (Revision 4/15/82) was not followed in that circuits 2, 23 and 57 were found with their control room temperature alarms in the blocked position without operating condition justification at 2:00 p.m. on September 17, 1982. (This is a repeat of violation cited in Inspection Report 82-21).

RESPONSE:

1. FPL concurs with the finding.

2. The switches had been put in the block position for valid reasons, but because of the previously inadequate management attention to heat tracing, the Nuclear Operators did not devote enough attention to promptly returning the switches to the normal position when the circuits were restored to normal.

3. As immediate corrective action, Heat Tracing Circuits 2, 23 and 57 normal/block switches were placed in the normal position. The Nuclear Operators were instructed to return these switches to normal when the Heat Tracing circuits return to normal.

4. As long term corrective action, special training classes on heat tracing were conducted to prevent recurrence of this violation. Attendance was required for the following classifications: Plant Supervisor - Nuclear, Nuclear Watch Engineer, and the Nuclear Operators.

5. Full compliance was achieved by 12/17/82.

FINDING B:

B. Technical Specification 6.8.1 requires that procedures be implemented. Operating Procedure 0190.19, Control of Maintenance on Nuclear Safety Related and Fire Protection Systems, specifies requirements for the completion of a Plant Work Order prior to performing maintenance on safety related systems.

Contrary to the above, Steps 8.1.4 and 8.1.8 of Operating Procedure 0190.19 were not completely followed on September 14, 1982, thus allowing maintenance to be performed on the Reactor Protection System without the use of an approved procedure. This resulted in the Unit 4 reactor trip from 100% power on September 15, 1982, at 1:27 a.m.

ATTACHMENT

RE: TURKEY POINT UNITS 3 AND 4
DOCKET NOS. 50-250, 50-251
IE INSPECTION REPORT 82-30

RESPONSE:

1. FPL concurs with the finding.

2. This situation occurred because the QC Inspector who reviewed this Plant Work Order (PWO) by telephone was awakened at home in the early morning and was not familiar enough with all of the requirements when pre-reviewing PWOs.

3. The Plant Work Order was subsequently reviewed by the QC Inspector and all deficiencies corrected. The QC inspector and the maintenance personnel involved were re-instructed on proper completion of PWO's necessary prior to contacting Quality Control for a pre-review.

4. To avoid this happening in the future, a QC Inspector's Pre-Review Checklist has been prepared and is used to remind Quality Control Inspectors of the numerous items that should be checked when pre-reviewing Plant Work Orders at the plant or by telephone.

5. Full compliance was achieved by October 22, 1982.

FINDING C:

C. Technical Specification 6.8.1 requires that procedures be implemented. Administrative Procedure 0103.5, Administrative Control of Valves, Locks and Switches specifies the methods to control locked valves.

Contrary to the above, the lock observed (on September 16, 1982) to be missing from valve 4-20-239, 4B Steam Generator Supply from the Auxiliary Feedwater Pump was not logged in the "Lock Deviation List" as required by Step 8.2.3 of Administrative Procedure 0103.5.

RESPONSE:

1. FPL concurs with the finding.

2. The reason for this violation was that with Unit 4 in hot shutdown, valve 4-20-239 was unlocked and closed to repair the upstream flow control valve. The repairs were completed on the same day and valve 4-20-239 was re-opened, but not locked.

3. This valve was locked in the open position immediately after the Plant Supervisor - Nuclear was notified of the deviation.

4. The importance of valves, breakers and locks being in the proper position was re-emphasized to all operators. Also stressed was that deviations from Administrative Procedure 0103.5, Administrative Control of valves, locks and switches must be logged.

5. Full compliance was achieved by December 7, 1982.