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L-86-45

Dr. J. Nelson Grace  
Regional Administrator, Region II  
U.S. Nuclear Regulatory Commission  
Suite 2900  
101 Marietta Street, N.W.  
Atlanta, Georgia 30323

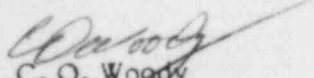
Dear Dr. Grace:

Re: Turkey Point Units 3 & 4  
Docket Nos. 50-250 and 50-251  
Inspection Report 250/85-42 and 251/85-42

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

There is no proprietary information in the report.

Very truly yours,

  
C. O. Woody  
Group Vice President  
Nuclear Energy

COW/SAV:dh

Attachment

cc: Harold F. Reis, Esquire  
PNS-LI-86-31

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## ATTACHMENT

Re: Turkey Point Units 3 and 4  
Docket No. 50-250, 50-251  
IE Inspection Report 250-85-42 & 251-85-42

### FINDING 1:

Technical Specification (TS) 6.8.1 requires that written procedures and administrative policies be established, implemented, and maintained that meet or exceed the requirements and recommendations of sections 5.1 and 5.3 of ANSI N18.7-1972 and Appendix A of USNRC Regulatory Guide 1.33.

Appendix A of USNRC Regulatory Guide 1.33 recommends that written procedures be established covering operation of the nuclear instrument system and the feedwater system.

### FINDING 1a:

Off-normal operating procedure 12108, Source Range Nuclear Instrumentation Malfunction, dated August 22, 1984, requires (section 5.2.1) that a failed instrument be taken out of service by placing the level trip switch in the bypass position.

Contrary to the above, on November 30, 1985, a Unit 3 source range nuclear instrument (N-32) was taken out of service without placing the level trip switch in the bypass position. Subsequently, when the instrument was re-energized, an electrical surge generated an input signal spike which was not bypassed and exceeded the instrument's trip set-point. The trip signal from the instrument caused an actuation of the reactor protection system.

### RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the finding in Item 1.a was that the operator involved failed to consult with and follow the requirement of both Operating Procedure 0205.1, "Unit Shutdown - Full Load to Hot Standby Condition", and Off-Normal Operating Procedure (OP) 12108, "Source Range Nuclear Instrumentation Malfunction", to place the trip level switch in the bypass position prior to removing and re-inserting the source range nuclear instrumentation (N-32) fuses.
- 3) The operator involved was counseled by supervisory personnel who stressed the need to consult with and follow plant procedures. Additionally, for the benefit of other operating personnel, a reminder was written into the night order book emphasizing the need to adhere to plant procedures.

- 4) This incident, which was reported in Licensee Event Report (LER) 250-85-040 under the requirements of 10CFR50.73, will be presented to the 1985-1986 Cycle V operator requalification classes as part of a series of on-going Feed-Back of Operating Experience and LER lectures. The enabling objectives related to this incident will center on the need to adhere to plant procedures as presented in the Verbatim Compliance Policy of Appendix A to Administrative Procedure 0103.2, "Responsibilities of Operators and Shift Technicians...".
- 5) Full compliance for Item 4 above will be achieved by February 14, 1986.

**FINDING 1b:**

Operating Procedure 3-OP-074, Steam Generator Feedwater Pump, dated September 11, 1985, requires (section 5.1.1) that the condensate system be aligned for normal operation in accordance with procedure 3-OP-073, Condensate System, as an initial condition prior to starting a steam generator feedwater pump.

Contrary to the above, on December 4, 1985, the 3B steam generator feedwater pump was started and the initial condition of section 5.1.1 of 3-OP-074 was not met. The subsequent trip of the 3B steam generator feedwater pump due to the improper condensate system alignment resulted in an initiation of the auxiliary feedwater system.

**RESPONSE:**

- 1) FPL concurs with the finding.
- 2) Prior to the heat-up, the feedwater and condensate systems were aligned for a recirculation cleanup, which required the closure of the SGFW pump suction valves. The operating shift preceeding the event began the process of returning the two secondary systems to a normal alignment after the recirculation cleanup was complete, but failed to communicate the proper status of this alignment to the subsequent operating shift. For the above reason, the subsequent operating shift failed to verify the alignment of the two secondary systems to comply with Operating Procedures 3-OP-074, "SGFW Pump", and 3-OP-073, "Condensate System".
- 3) The following corrective actions were taken following this incident:
  - a) Upon identification that the condensate and feedwater system alignments had not been finished, these system alignments were completed in accordance with plant procedures.
  - b) The operators involved were counseled by supervisory personnel, who emphasized the need for clear and concise intershift turn-overs.

- c) Plant Operating Procedures 3-OP-073 and 4-OP-073 were revised to require a plant clearance for the SGFW pump motor breaker to ensure that these pumps cannot be started while the two secondary system alignments remain in the recirculation cleanup mode.
- 4) This incident, which was reported in Licensee Event Report (LER) 250-85-041 under the requirements of 10CFR50.73, will be presented to the 1985-1986 Cycle V operator requalification classes as part of a series of on-going Feed-Back of Operating Experience and LER lectures. The enabling objectives related to this incident will center on the need to adhere to plant procedures as presented in the Verbatim Compliance Policy of Appendix A to Administrative Procedure 0103.2, "Responsibilities of Operators and Shift Technicians...".
- 5) Full compliance for Item 4 above will be achieved by February 14, 1986.