P.O. BOX 529100 MIAMI, FL 33152

USNRC REGION II
ATLANTA, GEORGIA

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FPL
FLORIDA POWER & LIGHT COMPANY

March 1, 1982
L-82-71

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 & 4
Docket Nos. 50-250 and 50-251
IE Inspection Report 81-33

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

There is no proprietary information in the report.

In addition, you expressed concern over the plugging of the boron injection tank (BIT) inlet piping. You asked us to discuss the actions we have taken to improve the effectiveness of our management controls in this area. As noted in our response to the finding, we have made procedure changes to address temperature testing of the BIT lines, and we will make further procedure changes to provide enhanced administrative controls in this area.

Very truly yours,

R. W. Williams, Jr. for

Robert E. Uhrig
Vice President
Advanced Systems & Technology

REU/PLP/mbd

Attachment

cc: Harold F. Reis, Esquire

ATTACHMENT

RE: TURKEY POINT UNITS 3 AND 4
DOCKET NOS. 50-250 AND 50-251
IE INSPECTION REPORT 81-33

FINDING A:

10 CFR 50, Appendix B, Criterion XVI and 10 CFR 50 Appendix B, Criterion X requires a program for inspection of activities affecting quality be established and executed to verify conformance with documented instructions accomplishing the activity.

FPL approved Quality Assurance Manual, Section 16.1 requires that corrective action procedures shall be used to assure that nonconforming items and conditions which might affect the quality and safe operation are identified early and corrected.

Contrary to the above, inspection activities failed to detect or correct the deterioration of lagging on a portion of the Unit 4 Boron Injection Tank (BIT) suction piping. This deterioration resulted in the crystallization of boron solution and the loss of capability to inject the BIT solution as detected during testing on October 21, 1981.

RESPONSE:

(1-1) FPL concurs with the finding.

(1-2) Existing administrative controls did not place sufficient emphasis on maintaining the material condition of the lagging on heat traced Boric acid lines.

(1-3) As corrective action, the insulating material was reinstalled immediately after becoming aware of the problem.

(1-4) The incident was evaluated by the Technical Department and the following corrective action taken or planned:

1) Operating Procedure 4104.1, High Head Safety Injection System - Periodic Test, has been changed to include, as part of each monthly test, a local temperature check with a pyrometer and three points were located on each inlet and outlet pipe of the BIT and were prepared so the piping temperature may be measured by a contact pyrometer. Appropriate operations logsheets have been revised to provide increased assurance that heat tracing recorders are operating properly and that the temperatures recorded are accurate.

2) Administrative Procedures 0190.19 and 0190.70 are being revised to provide enhanced administrative controls on the heat traced inlet and outlet lines to and from the BIT.

3) Administrative Procedure 0103.11, Housekeeping, has been changed to specifically indicate that the BIT Room is a nuclear safety related area.

(1-5) Full compliance will be by April 2, 1982.

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FINDING B:

Technical Specification 3.10.1 requires that during refueling operations at least one door in the personnel air lock be closed.

Contrary to the above, on November 16, 1981, both personnel air lock doors were simultaneously open for approximately one hour during Unit 4 refueling operations.

RESPONSE:

(2-1) FPL concurs with the finding. This was reported as Reportable Occurrence 251-81-13 (11/30/81).

(2-2) The reason for the finding could not be determined.

(2-3) As corrective action, one of the two doors was closed and the door interlocks were repaired. What information we have indicates the door was shut within minutes of the condition being found and the interlocks were repaired shortly thereafter.

(2-4) Plant Change/Modifications 81-150 and 81-151 have been initiated to add a additional "personnel door interlock violated" logic. The sensing switches for this logic will be located on the personnel hatch doors. Anytime both doors are open this logic will insure the annunciator is alarmed by providing a parallel channel to the existing logic which senses latch positions. Additionally all plant and contract personnel will be instructed on the importance of maintaining containment integrity when required.

(2-5) Full compliance with Technical Specification 3.10.1 was achieved when the door was closed.

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FINDING C:

Technical Specification 6.8.1 requires that written procedures, and administrative policies be established and implemented for maintenance of safety-related equipment. Paragraph 3.2 of Administrative Procedure 0190.19, Control of Maintenance on Nuclear Safety Related and Fire Protection Systems, states a Plant Work Order is required for work on nuclear safety related or fire protection systems.

Contrary to the above:

1. A ball valve on the drain line of the Unit 4 Boron Injection Tank was removed at some time during the period of September 26, 1981, to October 25, 1981, without the authorization of a Plant Work Order.

2. Portions of the maintenance performed on the "A" emergency diesel generator on November 10, 1981, were not performed in accordance with applicable plant procedures.

RESPONSE:

(3-1) FPL concurs with the finding.

(3-2) The cause of the drain valve problem was the foreman/supervisor did not consider the work to be "safety related". The emergency diesel procedural error was an oversight in two areas:

1) The mechanic did not have all documentation in the field that he should have had and

2) He inadvertently was following verbal directions from the vendor directing the work.

(3-3) The corrective action taken in both items was to review the error with the people involved. In all cases the personnel involved responded positively, acknowledged the error, and are now committed to have no further occurrences.

(3-4) Since these two incidents occurred, all personnel in the Mechanical Maintenance Department have been reminded of the policy on procedural compliance. In addition, the GEMS planners and supervisors have been instructed to insure complete documentation as referenced on the PWO available to the personnel in the field.

(3-5) Full compliance was achieved on February 22, 1982.

STATE OF FLORIDA )
) ss.
COUNTY OF DADE )

J. W. Williams, Jr., being first duly sworn, deposes and says:

That he is Vice President of Florida Power & Light Company, the herein;

That he has executed the foregoing document; that the statements made in this said document are true and correct to the best of his knowledge, information, and belief, and that he is authorized to execute the document on behalf of said

J. W. Williams, Jr.

Subscribed and sworn to before me this 1st day of March, 1982

Cheryl L. Fredrick
NOTARY PUBLIC, in and for the County of Dade, State of Florida

Notary Public, State of Florida at Large
My Commission Expires October 30, 1983
Bonded thru Maynard Bonding Agency

My commission expires: