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L-86-309

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

Dear Dr. Grace:

Re: Turkey Point Units 3 and 4  
Docket Nos. 50-250 and 50-251  
Inspection Report 86-25

Florida Power & Light Company has reviewed the subject inspection report and a response is attached. Our response to Finding D.2 will be provided by August 6, 1986.

There is no proprietary information in the report.

Very truly yours,

*J.M. Padavano Jr*  
for C. O. Woody  
Group Vice President  
Nuclear Energy

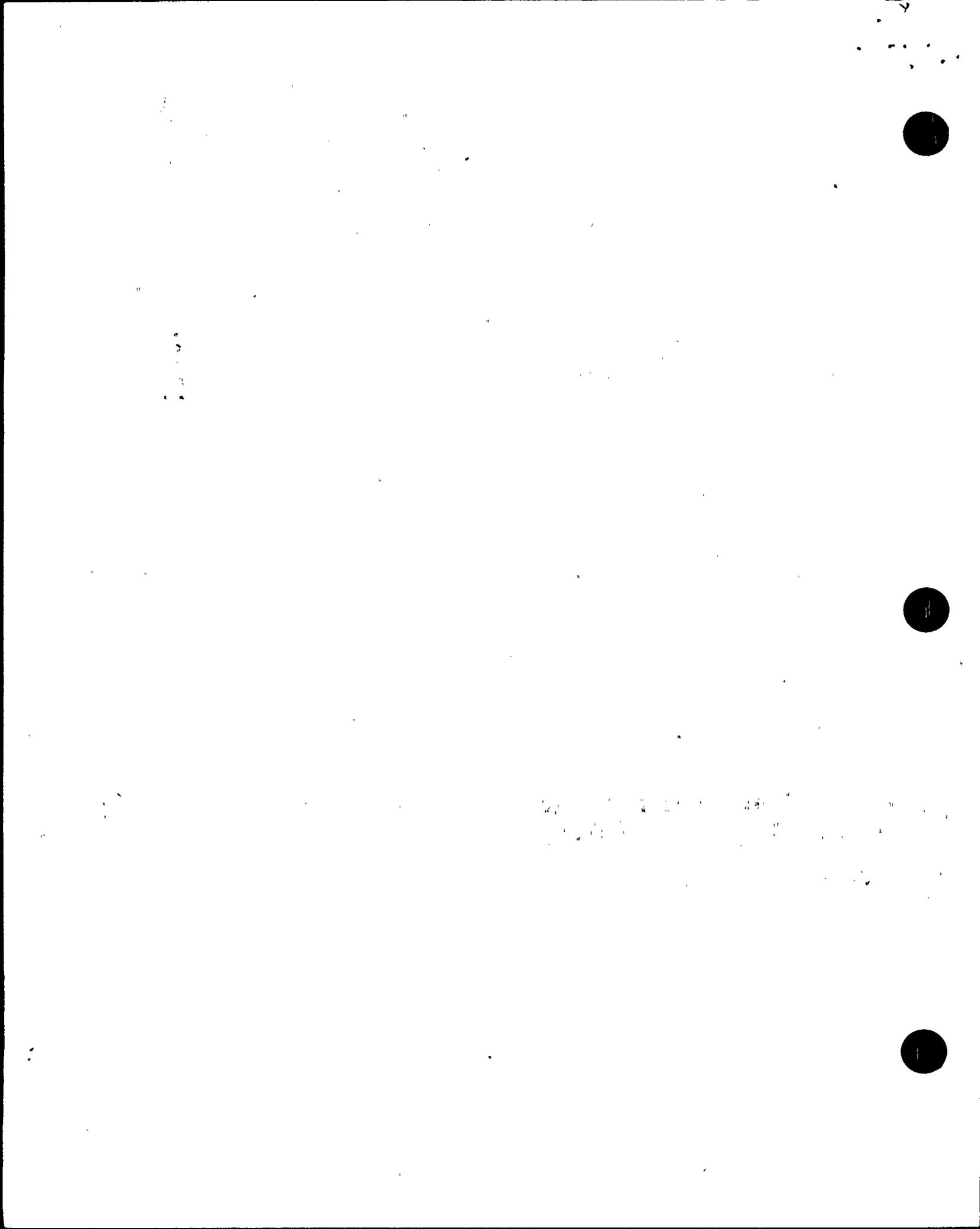
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Attachments

cc: Harold F. Reis, Esquire  
PNS-LI-86-225

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## ATTACHMENT

Re: Turkey Point Units 3 and 4  
Docket No. 50-250, 50-251  
IE Inspection Report 250-86-35 & 251-86-25

### FINDING A:

Technical Specification 6.8.1 requires that written procedures and administrative policies be implemented 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 states that administrative procedures specifying procedure adherence should be established.

Administrative Procedure O-ADM-201, Upgrade Operations Procedure Usage, dated December 4, 1985, requires, in section 5.5.1, that operating procedures be followed exactly and that all personnel comply with approved procedures applicable to the activity or circumstance being performed.

### FINDING A.1:

Operating Procedure (OP) 1004.2, Reactor Protection System - Periodic Test (Unit 3 Only), dated February 7, 1986, requires, in section 8.61, that the operator proceed to protection instrument rack 41 to perform train "B" reactor trip breaker testing. Section 8.63 directs the operator to trip the "B" reactor trip breaker.

Contrary to the above, on May 2, 1986, an operator failed to properly implement OP 1004.2, in that while performing step 8.61 he remained at protection instrument rack 36 and, while performing step 8.63, tripped the "A" reactor trip breaker thereby inadvertently tripping the Unit 3 reactor.

### RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the finding was that the operator who had the procedure in hand did not note that the procedure step required the second operator performing the action to move to a different protection rack.
- 3) The following corrective actions were taken:
  - a) The two operators involved were counselled on the importance of adherence to procedures.
  - b) An entry was made in the short term instruction book to reinforce the importance of adherence to procedures to the operating crews.
  - c) OP 1004.2 was satisfactorily completed prior to the Unit 3 restart.

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- 4) OP 1004.2 has been replaced by \*-OSP-049.1, Reactor Protection System Logic Test. The new procedure was in the review process at the time of the event and the review was expedited to issue the new procedure. In addition to being in the upgraded procedure format \*-OSP-049.1 also includes:
  - a) A requirement that all the operators involved have a copy of the procedure in hand to verify specific actions.
  - b) Ensures only one action per step.
  - c) The changing of protection racks is now a several step process requiring more than one deliberate action.
- 5)
  - a) Full compliance for Item 3 above was achieved by May 5, 1986.
  - b) Full compliance for Item 4 above was achieved by May 23, 1986.

FINDING A.2:

OP 4304.1, Emergency Diesel Generator - Periodic Test Load on 4KV Bus, dated April 1, 1986, requires, in section 8.3, that the starting air supply valve be closed for the Emergency Diesel Generator (EDG) being tested. Section 8.7 requires that the starting air supply valve for the EDG be reopened after completion of sections 8.3 through 8.6.

Contrary to the above, on May 2, 1986, an operator failed to properly implement OP 4304.1 on two consecutive occasions, in that during an initial start of the "B" EDG, Section 8.7 was not implemented, causing the EDG to fail to start. While realigning the "B" EDG for a subsequent start attempt, the operator improperly implemented Section 8.3 in that he closed the starting air supply valve for the "A" EDG, rendering the "A" EDG temporarily inoperable.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the finding was that the operator involved failed to follow the procedure and verbal instructions from his supervisor.
- 3) The valves were repositioned and both the A and B EDGs were satisfactorily tested and placed back in service.
- 4) The following corrective actions have been taken:
  - a) The operator involved was counselled on the importance of adherence to procedures and verbal instructions.
  - b) To help prevent closing the wrong valve, the locks were changed to be EDG specific.



- c) OP 4304.1 has been revised to make step 8.7 more user friendly and to add independent verification of the step.
- 5) a) Full compliance for Item 3 above was achieved by May 2, 1986.
- b) Full compliance for Item 4 above was achieved by May 13, 1986.

**FINDING A.3:**

OP 4304.1, Emergency Diesel Generator - Periodic Test Load on 4KV Bus, dated April 1, 1986, requires, in Section 8.11, that the fuel oil prime pushbutton be depressed and that fuel oil pressure be verified to be approximately 25 to 30 psig.

Contrary to the above, on May 9, 1986, an operator failed to properly implement OP 4304.1, in that, during a lineup to start the "B" EDG, Section 8.11 was not properly implemented because the operator pressed the local start pushbutton instead of the fuel oil prime pushbutton. This action caused an unexpected local start of the "B" EDG.

**RESPONSE:**

- 1) FPL concurs with the finding.
- 2) The reason for the finding was that the operator inadvertantly pushed the wrong button on the EDG local panel during the performance of OP 4304.1.
- 3) The "B" EDG was stopped and the test was recommenced and satisfactorily completed.
- 4) The operator involved was counselled on the importance of adherence to procedures and reading the component label prior to actuating to ensure that the proper action is being performed.
- 5) a) Full compliance for Item 3 above was achieved on May 9, 1986.
- b) Full compliance for Item 4 above was achieved on June 5, 1986.

**FINDING B:**

Technical Specification 6.8.1 requires that written procedures and administrative policies be established 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 Regulatory Guide 1.33 states that procedures should be established for the startup, operation and shutdown of safety-related equipment including instructions relative to emergency power sources such as diesel generators.

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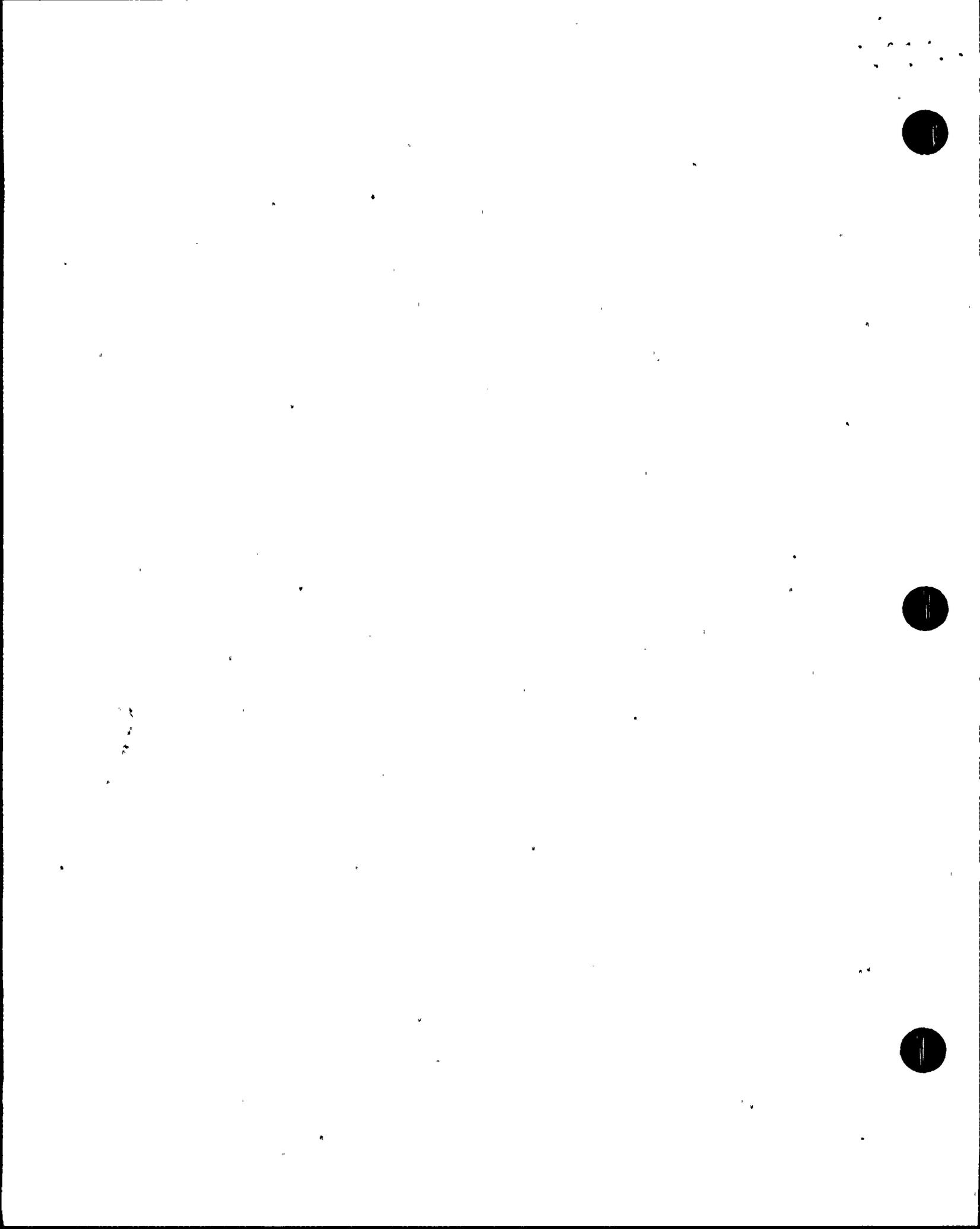
Procedure 0-OP-023, Emergency Diesel Generator, dated March 25, 1986, provides instructional guidance for the startup, normal operation and shutdown of the EDG system.

Contrary to the above, as of May 12, 1986, procedure 0-OP-023 did not adequately establish procedures for the startup and operation of the "A" and "B" EDGs, in that:

1. The procedure did not address the control of valves 292 and 293 for either the "A" or "B" EDG radiator cooling water system drains, and the drain valves for the "A" or "B" EDG fuel oil skid tank;
2. The procedure addressed the position of skid tank solenoid valve SV-3-3522 bypass line isolation valve 70-048A, which has not been installed for the "A" EDG; and
3. The procedure did not address the control of valve 269B for the starting air flask drains for the "B" EDG.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The reason for the finding is as follows:
  - a) EDG Cooling Water System valves 292A(B) and 293A(B) were not contained in the procedure because they are not manipulated in the procedure and because Nuclear Chemistry Procedure NC-100A, Chemical Treatment of the Component Cooling Water System and the Emergency Diesel Generator, addresses makeup and chemical control of the EDG Cooling Water System.
  - b) Valve 70-048A was supposed to be added to the A EDG fuel oil fill line in accordance with Plant Change/Modification (PC/M) No. 85-196 along with valve 70-048B on the B EDG. The PC/M partial turnover notification documentation was received and the request for procedure change, which incorporated PC/M 85-196, was released for review and approved. The documentation did not specify that valve 70-048A was not installed on the A EDG and therefore, it remained in the proposed change that was approved and distributed.
  - c) When 0-OP-023 was originally generated, the system print did not reflect the air flask header drain valve 269B. During the walkdown of the system (to support the procedure generation) the valve was missed due to its location. The air flask drain isolation valves 267B, 268B, 270B and 271B were located and included in procedure for the purpose of isolating the air flasks from the drain.



- 3) The following corrective actions were taken:
- a) A new valve alignment section has been added to the procedure for the purpose of aligning the EDG Cooling Water System. Valves 292A, 292B, 293A, and 293B have been included in the alignment along with the Cooling Water System drain valves 294A and 294B.
  - b) O-OP-023 was revised on June 11, 1986 to remove valve 70-048A from the valve alignment for the A EDG. Since that time, valve 70-048A has been installed on the A EDG and O-OP-023 was revised on July 1, 1986 to include 70-048A in the valve alignment for the A EDG.
  - c) Valve 269B has been added to the valve alignment. Also, the air flask drain valves that have now been labeled on drawing 5610-T-E-4536 have been numbered in the alignment section of the procedure.
- 4) Several discussions between the cognizant Procedure Upgrade Program personnel have been held to identify the root causes and to prevent further occurrences.
- 5) a) Full compliance for Item 3 above was achieved by July 1, 1986.  
b) Full compliance for Item 4 above was achieved by June 1986.

FINDING C:

10 CFR 50, Appendix B, Criterion VI, as implemented by FPL Topical Quality Assurance Report (FPL-NQA-100A) Revision 8, TQR 6.0, Document Control, requires, in part, that the distribution of controlled documents; such as drawings, which provide guidance, specifications or requirements affecting the quality of nuclear safety-related structures, systems and components, shall be controlled and that Quality Procedures shall delineate the control measures for drawings, including direction for the review for adequacy.

FPL Quality Assurance Manual, Quality Procedure (QP) 6.6, Revision 1, delineates requirements for maintaining the drawing update program and assuring that drawings reflect the as-constructed configuration of the safety-related system.

Administrative Procedure (AP) 0103.10, Using and Updating Plant Drawings, dated March 3, 1983, implements the above requirements and specifies that drawings shall be field verified to ensure proper accuracy.

Contrary to the above, as of May 13, 1986, drawing 5610-T-E-4536, Revision 0, sheets 1 and 2, entitled "Diesel Generator A" and "Diesel Generator B", respectively, were not accurate, in that:

1. The drawing sheets failed to show the existence of a fuel oil skid tank drain valve for each EDG;
2. The drawing sheets showed that valves 292A and 292B, drains for the EDG radiator cooling system, were normally closed valves when actually they were normally open valves;

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3. Numerous valve numbers specified on the drawing sheets conflicted with the valve numbers utilized by approved operating procedure O-OP-023; and
4. Drawing sheet 1 showed the presence of starting air flask drain valve 269A, which does not exist, and drawing sheet 2 showed a starting air flask drain piping configuration which was not accurate.

RESPONSE:

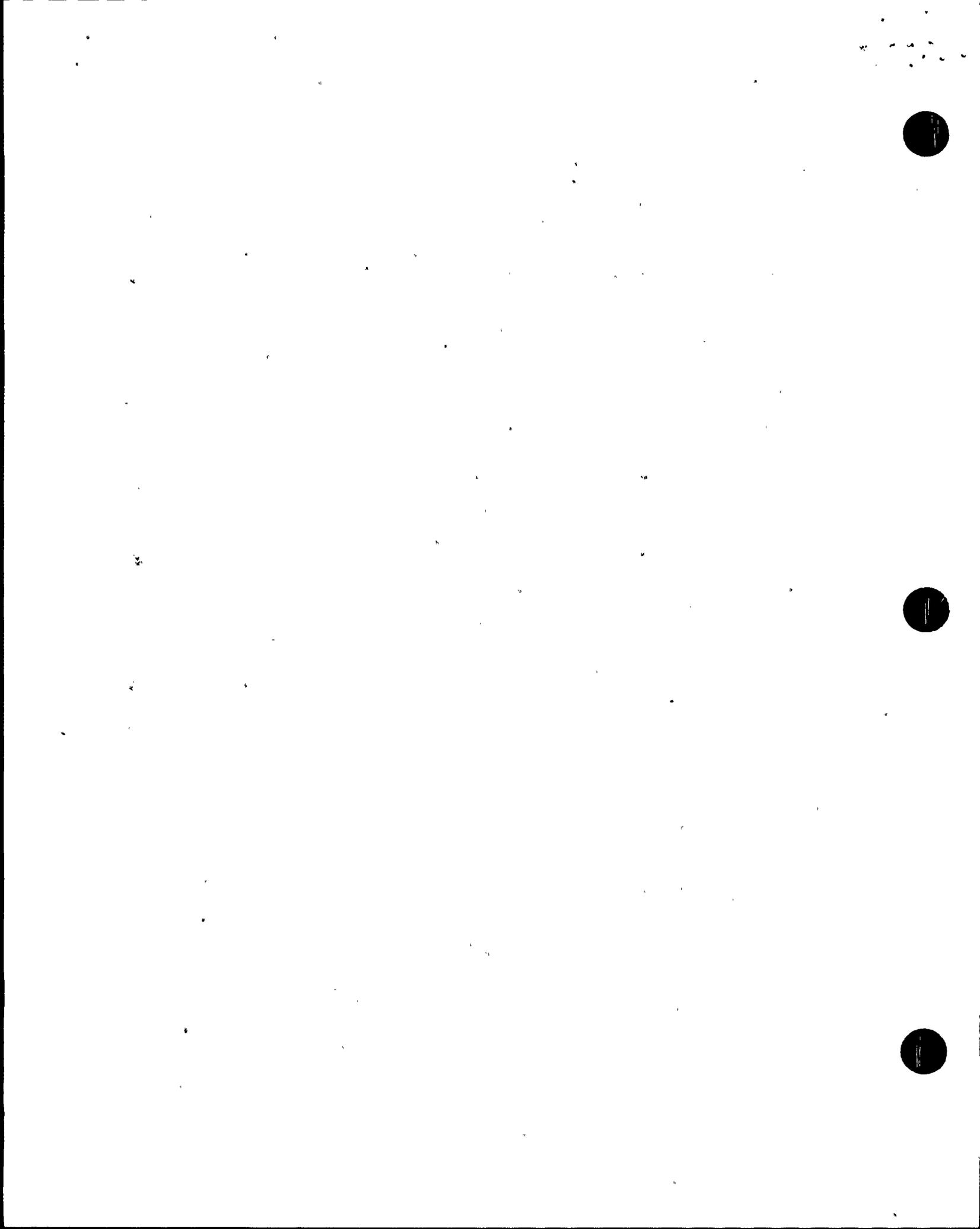
- 1) FPL concurs with the finding.
- 2) The reason for the finding was that the drawing was not completely field verified prior to issuance.
- 3) Drawing 5610-T-E-4536, sheets 1 and 2 will be revised to correct the items discussed above and ensure the drawing accurately represents the field configuration.
- 4)
  - a) As a part of the ongoing selected safety system review, a walkdown of systems is being performed to ensure that the existing drawings accurately represent the configuration in the field.
  - b) This event will be discussed with drawing update personnel to re-emphasize the importance of issuing accurate drawings and the significance of this event.
- 5)
  - a) Full compliance for Item 3 above will be achieved by July 30, 1986.
  - b) Full compliance for Item 4.b above will be achieved by August 22, 1986.

FINDING D:

Technical Specification 6.8.1 requires that written procedures and administrative policies be implemented 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 states that administrative procedures specifying procedure adherence should be established.

AP 0190.19, Control of Maintenance on Safety Related and Quality Related Systems, revision dated January 8, 1986, states that the Plant Supervisor - Nuclear (PSN) may authorize work to start prior to obtaining Quality Control (QC) approval of the Plant Work Order (PWO) when the plant is in a load threatening condition or in an Action Statement of TS 3.0.1. To immediately commence work, the PSN shall originate a PWO and assign a class "AA" work priority and sign the permission to start work block. Maintenance technicians are required to thoroughly document all actions taken on the PWO, and the PWO shall be made available for subsequent review by the QC Department within one day.



FINDING D.1:

Contrary to the above, on April 9, 1986, PWO 6230 was issued as a priority class "AA" work order but the maintenance technician did not thoroughly document his maintenance actions, in that he failed to originate a calibration record sheet for a flow meter he installed. Additionally, he failed to indicate on the PWO that he had performed the required meter calibration.

RESPONSE:

- 1) FPL concurs with the finding.
- 2) The calibration record sheet was inadvertently omitted from the Plant Work Order (PWO) documentation because "AA" priority PWO's do not receive maintenance planning or QC review prior to accomplishment of work.
- 3) The indicator was calibration checked per the approved calibration procedure. It was found to be 2 GPM out of tolerance in the conservative direction.
- 4) Additional instructions have been issued to I and C Field Supervisors to provide the following guidance on work performed using "AA" priority PWO's. These instructions require the use of the formal troubleshooting procedure O-GMI-102.1 on all "AA" priority PWO's. This will ensure that formal procedures are used to identify the correct calibration procedures to be used for emergency repair of equipment.
- 5) a) Full compliance for Item 3 above was achieved on April 18, 1986.  
b) Full compliance for Item 4 above was achieved by May 14, 1986.

FINDING D.2:

Contrary to the above, on May 3, 1986, the PSN authorized work to start on priority class "AA" PWO 6379 when the plant was not in a load threatening condition nor in an Action Statement of TS 3.0.1. Additionally, the PWO was not made available for review by the QC Department within one day.

RESPONSE:

This finding is still under consideration. A response will be provided by August 6, 1986.

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