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SUBJECT: Responds to violations noted in Insp Repts 50-250/88-07 & 50-251/88-07.

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L-88-234

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

Gentlemen:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Reply to Notice of Violation
Inspection Report 88-07

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

Very truly yours,

W. F. Conway
Senior Vice President - Nuclear

WFC/SDF/gp

Attachment

cc: Dr. J. Nelson Grace, Regional Administrator,
Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

SDF.IR

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ATTACHMENT

RE: TURKEY POINT UNITS 3 AND 4
DOCKET NO. 50-250, 50-251
IE INSPECTION REPORT 250-88-07 & 251-88-07

FINDING:

Technical Specification (TS) 6.8.1 requires that written procedures and administrative policies shall be established, implemented, and maintained that meet or exceed the requirements and recommendations of Appendix A of USNRC Regulatory Guide 1.33.

Regulatory Guide 1.33, Appendix A, Item 8.b(1).(r), specifies that specific procedures should be written for surveillance tests and inspections for the auxiliary feedwater (AFW) system.

FINDING A.1:

Operating Procedure 0204.2, entitled Periodic Tests, Checks, and Operating Evolutions, revision dated February 11, 1988, requires in Section 8.4.7, that the Unit 3 AFW Backup N2 Supply Station No. 1, Trains 1 and 2, on and off-line bottle pressures be verified. Step 6 requires the pressure indicators (PI) be vented through the Bottle Outlet PI Test Connections and that the valves be closed and recapped.

Contrary to the above, on February 23, 1988, valve 3-40-1688, vent valve Train 1 Bottle 1, AFW N2 Backup was found lockwired open and mechanically capped.

Contrary to the above, on March 28, 1988, valve 3-40-1687, PI-3-7001 root valve, AFW N2 Backup was found lockwired open.

RESPONSE:

1) FPL concurs with the finding.

2) The cause for the failure to close the valves as required by procedure OP 0204.2 was personnel error due to a human factors problem with OP 0204.2. The step requiring the closure of the valves contained multiple valve manipulations on a complex system with several actions within a single step.

3) Immediate actions were taken to place the valves in the proper position. The mispositioning of the valves did not affect the operability of the system.

4) a) An On-The-Spot Change (OTSC) to procedure OP 0204.2 to break the action statements discussed above into individual steps and provide for independent verification of the steps was generated.

b) Plant Change/Modifications were implemented to provide seismic gauges which will remain valved in at all times. The PC/M implementation included procedure changes reflecting the elimination of the need to perform the above valve manipulations.

c) The Operations Superintendent and Operations Supervisor are holding meetings with each shift on work controls, attention to detail during performance of duties, and contributors to human error at Turkey Point.

5) a) Full compliance for item 3 above was achieved by February 23, 1988, and March 28, 1988, respectively.

b) Full compliance for item 4a above was achieved by February 25, 1988.

c) Full compliance for item 4b above was achieved by April 14, 1988.

d) Full compliance for item 4c above will be achieved by July 1, 1988.

FINDING A.2:

Regulatory Guide 1.33, Appendix A, Item 1.c, specifies that written procedures should be developed for equipment control.

AP 0103.4, entitled In-Plant Equipment Clearance Orders, revision dated February 2, 1988, Section 4.21, specifies that temporary lifts shall be used to perform testing evolutions that require rehanging the clearance upon the completion of the test. Section 8.7.3 further specifies that a temporary lift should not be in effect for more than 24 hours.

Contrary to the above, on three occasions, clearance order 4-87-11-23 for valve 4-349G, the 4B Boric Acid Transfer Pump (BATP) Discharge pressure indication isolation valve, was not being maintained.

a. On February 11, 1988, valve 4-349G was found opened on a Temporary Lift dated January 26, 1988, for the Inservice Testing (IST) of the 4B BATP. The Temporary Lift was not released upon completion of the IST, thus the valve was left open.

b. On February 17, 1988, valve 4-349G was found open and clearance tag 4-87-11-23 was missing. There was no record of a Temporary Lift which would open the valve.

c. On March 3, 1988, valve 4-349G was again found open on a Temporary Lift dated February 29, 1988.

RESPONSE:

1) FPL concurs with the finding.

2) The reasons for this violation are as follows:

a) In this particular instance, the administrative controls placed on valve 4-349G were inadequate in that proper valve position following an evolution was not assured.

b) The Operations Department has no tracking mechanism for tracking temporary lifts for longer than than 24 hours. Some testing requires more than 24 hours.

3) In each instance, upon identification, the valve was immediately placed in the proper position.

4) Due to the repetitive nature of this issue, a full review of the temporary lift process, and administrative controls for similar situations, will be performed.

5) a) Full compliance for item 3 above was achieved by March 3, 1988.

b) Full compliance for item 4 above will be achieved by July 31, 1988.

FINDING A.3:

AP 0103.4, also provides, in section 8.3.12, instructions for tag-out and removal of clearance orders. Clearance order 3-88-061, dated March 19, 1988, required that valve 4-371, 4A Intake Cooling Water heat exchanger inlet isolation, be independently verified in the open position upon removal of the clearance tags.

Contrary to the above on March 20, 1988, valve 4-371 was found only to be approximately one-fourth open following removal of clearance 3-88-061, therefore reducing the required intake cooling water flow through the heat exchanger.

RESPONSE:

1) FPL concurs with the finding.

2) The reason for the valve not being fully open was inadequate verification of valve position following operation of the valve. The valve has a position indicator which is not visible from underneath the valve, which is where the field operators were located. The indicator is visible through grating above the valve, however the indicator is difficult to see as it is painted the same color as the valve gear box. The heat exchanger is provided with a flow indicator which could be utilized to determine if full flow was present. At the time of the event, the flow indicator was removed from the heat exchanger, and this method of verification was not available. The operators felt that adequate verification of the open valve position would be provided by the valve stop, which would be reached upon the valve being fully open. The valve was manually opened, (by pulling on the chain valve operator) and upon reaching the point at which the operator could not open the valve further, a second operator verified that the valve was at its most open position. This verification consisted of the second operator attempting to open the valve by the same method as was used by the first operator. As the valve was binding, this operator could not open the valve further, and felt that the valve was verified to be open.

3) a) The valve was promptly placed in the full open position.

b) The operators involved were counseled on the proper methods of verifying valve position.

c) The valve gearbox and position indicator were painted and stenciled to enable easier verification of valve position.

4) Valve position verification methods and independent verification of valve position will be addressed during the next requalification cycle of licensed and non-licensed operators.

5) a) Full compliance for item 3 above was achieved by April 13, 1988.

b) Full compliance for item 4 above will be achieved by July 1, 1988.