



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

Report Nos.: 50-250/88-18 and 50-251/88-18

Licensee: Florida Power and Light Company
9250 West Flagler Street
Miami, FL 33102

Docket Nos.: 50-250 and 50-251

License Nos.: DPR-31 and DPR-41

Facility Name: Turkey Point 3 and 4

Inspection Conducted: June 25, 1988 through July 25, 1988

Inspectors:

M. S. Lewis for
T. F. McElhinney, Resident Inspector

8/31/88
Date Signed

M. S. Lewis for
G. A. Schnebli, Resident Inspector

8/31/88
Date Signed

Approved by:

R. V. Crlenjak
R. V. Crlenjak, Section Chief
Division of Reactor Projects

8/31/88
Date Signed

SUMMARY

Scope: This routine, unannounced inspection entailed direct inspection at the site, including backshift inspection, in the areas of annual and monthly surveillance, maintenance observations and reviews, engineered safety features, operational safety, facility security and plant events.

Results: One violation of TS 6.8.1 was identified. Failure to follow procedure, in that the Off Normal Operating Procedure (ONOP) for Reactor Control System Malfunction was not referred to with one Rod Position Indicator (RPI) greater than 12 steps misaligned with other RPIs in the same bank. (50-250,251/88-18-01) (paragraph 11). One URI was identified. Review the licensee's evaluation concerning the inoperable emergency fan SF-1B for the Control Room Ventilation System. (50-250,251/88-18-02) (paragraph 8).

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *J. S. Odom, Site Vice President
- *J. E. Cross, Plant Manager-Nuclear
- *L. W. Pearce, Operations Superintendent
 - J. A. Labarraque, Senior Technical Advisor
- *R. Santag, Acting Senior Technical Advisor
- *F. H. Southworth, Technical Department Supervisor
- *J. W. Kappes, Maintenance Superintendent
- *T. A. Finn, Training Supervisor
 - J. D. Webb, Operations - Maintenance Coordinator
 - W. R. Williams, Assistant Superintendent Planned Maintenance
 - D. Tomaszewski, Instrument and Control (I&C) Department Supervisor
 - J. C. Strong, Mechanical Department Supervisor
- *J. W. Anderson, Jr., Quality Assurance (QA) Superintendent
 - D. A. Chaney, Engineering Manager
- *G. M. Smith, Service Manager-Nuclear
 - R. J. Earl, Quality Control (QC) Supervisor
- *J. W. Brooks, QC Inspector
 - B. A. Abrishami, System Performance Supervisor
 - R. G. Mende, Operations Supervisor
- *J. Arias, Jr., Regulation and Compliance Supervisor
 - V. A. Kaminskis, Reactor Engineering Supervisor
 - R. D. Hart, Regulation and Compliance Engineer
- *G. Salamon, Regulation and Compliance Engineer
 - J. Donis, Engineering Department Supervisor
 - S. Hale, Engineering Project Supervisor
 - P. Higgins, Site Engineering-Licensing

Other licensee employees contacted included construction craftsmen, engineers, technicians, operators, mechanics, and electricians.

*Attended exit interview on August 1, 1988.

Note: An alphabetical tabulation of acronyms used in this report is listed in paragraph 15.

2. Unresolved Items (URI)

Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations of requirements or deviations from commitments. One unresolved item was identified in this report (paragraph 8).

3. Followup on Items of Noncompliance (92702)

A review was conducted of the following noncompliances to assure that corrective actions were adequately implemented and resulted in conformance with regulatory requirements. Verification of corrective action was achieved through record reviews, observation and discussions with licensee personnel. Licensee correspondence was evaluated to ensure that the responses were timely and that corrective actions were implemented within the time periods specified in the reply.

(Closed) Violation 250,251/87-22-01. Failure to follow clearance order procedure. The licensee concurred with the finding in letter dated July 10, 1987. The following corrective actions were taken; the operator involved was counseled on procedural compliance and a special instruction was issued to provide guidance for performing evolution briefings. This item is closed.

(Closed) Violation 251/87-35-01. Failure to perform a boron concentration analysis for the 4C accumulator prior to heating the primary coolant system above 200 degrees F. The licensee concurred with the finding in letter dated October 12, 1987. The following corrective actions were taken; Procedure 3/4-OP-041.8, Filling and Venting the Reactor Coolant System, was revised to require boron concentration sampling of the accumulators before establishing RCS integrity, Chemistry Procedure NC-8A, Primary Chemistry Surveillance during Reactor Startup Mode 6 or 5 through Mode 1, was revised to include boron concentration sampling of the accumulators before establishing RCS integrity, and finally, a Technical Specification change was submitted February 3, 1988, to revise the sampling requirements. This item is closed.

(Closed) Violation 250,251/87-35-03. Failure to verify the operability of the B emergency diesel generator within 24 hours when the A emergency diesel generator is out of service. The licensee concurred with finding in letter dated October 12, 1987. The following corrective actions were taken; Procedure OP-4304.5, Engineered Safety Features (ESF) Equipment Operability Verification with an Emergency Diesel Generator Inoperable, was revised to require testing of the opposite diesel generator prior to taking a diesel out of service and Plaques were placed in the control room and in the diesel generator rooms to remind operators of the surveillance requirements. This item is closed.

(Closed) Violation 250,251/87-51-01. Two examples of failure to follow procedure for not documenting relief turnovers completely and actions were not recorded in the Plant Supervisor's logbook. The licensee concurred with the findings in letter dated March 14, 1988. The following actions were taken; AP-0103.2 was revised to enhance the clarity of the RCO Shift Relief Checklists; training brief 215 was issued on formal turnovers; and O-ADM-207, Operations Instructions in the Event of a Situation not Addressed by Procedure, was revised to include checksheets to ensure that action receive documentation. This item is closed.



(Closed) Violation 250,251/87-32-01. Failure of licensed and non-licensed operators to review and acknowledge Training Reports. The licensee concurred with the finding in letter dated August 27, 1987. The following corrective action was taken; all sets of training reports were consolidated into a central set and maintained in the training building library; the training department reviews the reports for missed signatures on a monthly basis; deficient operators and the Operations Supervisor are notified of any operator who is more than 10 weeks behind; and if an operator is more than 13 weeks behind in his review, his Key card is pulled and site entry denied until he corrects the deficiency. This item is closed.

(Closed) Violation 250,251/86-44-02. Failure to Follow Pipe Support Procedure. The licensee concurred with the finding in letter dated February 12, 1987. A non-conformance report (NCR) 86-315 was issued to evaluate the impact of the inoperable support. The evaluation showed that the system would be operable with the support disconnected. Maintenance Procedure 0734, Safety Related Supports/Restraints Removal and Replacement, contains guidance for the removal and replacement of supports and a maintenance training program for support replacement was incorporated. This item is closed.

(Closed) Violation 250,251/87-39-02. Failure to Perform a required post maintenance test and installing an incorrect check valve in a safety related nitrogen system. The licensee concurred with the finding in letter dated November 25, 1987. The following corrective actions were completed; Administrative Site Procedure (ASP)-8, Corrective Action, was revised to require that any discrepancy report or NCR requiring work, include post testing requirements; the incorrect check valve was replaced with the correct pressure rated check valve; and a training session was held with the affected groups. This item is closed.

(Open) Violation 250,251/85-37-01. Failure to meet TS 4.5.2.B.3, Accumulator Check Valves Leak Testing. The only remaining open item is the engineering evaluation of the in-leakage test method. The evaluation completion dates are November 31, 1988, for Unit 3 and August 20, 1988, for Unit 4. This item will remain open.

4. Followup on Unresolved Items (URIs), Inspector Followup Items (IFIs), Inspection and Enforcement Information Notices (IENs), IE Bulletins (IEBs) (information only), IE Circulars (IECs), and NRC Requests (92701).

(Open) IFI 250,251/85-02-04. Evaluate the monitoring of loss of control voltage at the EDG. The evaluation has not been completed. The licensee has a new completion date of July 28, 1988, which was extended from April 28, 1988. This item will remain open.

(Closed) 250,251/78-CI-15. Tilting Disc Check Valves Fail to Close with Gravity in Vertical Position. The licensee performed a sample investigation of Safety Related and Quality Related check valves at the plant.



One check valve, of the 125 check valves sampled, was installed incorrectly. Power Plant Engineering recommended that the remaining check valves, approximately 500, be investigated. The additional valve inspections are being tracked in the integrated schedule as item number 1268 which is scheduled for completion June 15, 1989. This item is closed.

5. Onsite Followup and In-Office Review of Nonroutine Events (92700/92712)

The Licensee Event reports (LERs) discussed below were reviewed and closed. The inspectors verified that reporting requirements had been met, root cause analysis was performed, corrective actions appeared appropriate, and generic applicability had been considered. Additionally, the inspectors verified that the licensee had reviewed each event, corrective actions were implemented, responsibility for corrective actions not fully completed was clearly assigned, safety questions had been evaluated and resolved, and violations of regulations or TS conditions had been identified.

(Closed) LER 250/87-02, Unit 3 changed Operational Modes While a Phase A Containment Isolation Valve Was Inoperable. The failed solenoid for the isolation valve was replaced, the list of the containment isolation valves was updated to include CV-3-739, Component Cooling Water Return Line From The Excess Letdown Heat Exchanger, and a training brief on the event was issued. This item is closed.

(Closed) LER 250/87-22, Reactor Trip Breakers Open on Unit 3 While at Cold Shutdown Due to Spurious Spike Actuating the Intermediate Range Low Power High Flux Reactor Trip. The event was discussed in Inspector Report 250,251/87-35. The following corrective actions were taken; the 25 volt power supply connector locking mechanism was replaced; the power cables for NIS channel 32 and 36 were re-routed; and the event was included in the Licensed Operator Requalification Program. This item is closed.

(Closed) LER 250/87-24, Reactor Controls Manipulation by a Non-Licensed Person Under the Direct Supervision of a Licensed Operator. This event was discussed in detail in NRC Inspection Report 250,251/87-44. The corrective actions addressed by the LER have been taken. This item is closed.

(Closed) LER 250/87-26, Inadequate Testing of the Hydrogen Recombiner Line After Piping Modification. The licensee issued an NCR requiring a pressure test on the recombinder line, this test was performed. Additionally, The Plant Construction Administrative Site Procedure, ASP-2, Preparation of Site Procedures/Process Sheets, was revised to include the In Service Inspection (ISI) Coordinator in the routing of the Process Sheets for changes to class A, B, C systems. This item is closed.

(Closed) LER 250/87-27, Transport of Contaminated Seal Injection Filter Causes Actuation of Process Radiation Monitor R-11 Resulting in Containment Vent and Control Room Ventilation Isolation. This event was

discussed in detail in NRC Inspection Report 250,251/87-48 and resulted in a violation 250,251/87-48-01 for failure to follow health physics procedures. This item is closed.

(Closed) LER 250/87-29, Waste Gas System Operated in a Configuration Not Described in the Final Safety Analysis Report During Volume Control Tank Purge Operations. Procedure 3/4-OP-47.1, VCT Gas Space Concentration Control, was revised to ensure that the FSAR requirements were being met and Procedure O-ADM-100, Procedure Preparation, Review and Appraisal, requires new procedures to have an evaluation checklist performed, which requires having the procedure reviewed against the FSAR. This item is closed.

(Closed) LER 250/87-31, Control Room Ventilation Isolation Due to Loss of Power to Containment Particulate Monitor Caused by Ground in Blowdown Effluent Radiation Monitor. This event is similar to the event in LER 250/87-32 which occurred December 17, 1987. The corrective action taken in LER 250/87-32 should preclude similar events in the future. This item is closed.

(Closed) LER 250/87-32, Control Room Ventilation Isolation Upon Containment Radioactive Particulate Monitor Actuation Due to Faulty Remote Readout on Blowdown Effluent Radiation Monitor. The cause of the monitor actuation was due to breaker 3P08-19 tripping. This breaker tripping was caused by corrosion found on the buzzer coil and light socket which resulted in a ground. The radiation monitor was replaced with a new drawer of different design and a change request lifted the leads from the meter, buzzer and light, removing the potential for grounds. This item is closed.

The following events are all similar and resulted in Containment Ventilation and Control Room Ventilation system isolation.

(Closed) LER 251/87-03, Process Radiation Monitor Spikes Cause Control Room Ventilation and Containment Vent Isolation.

(Closed) LER/251-87-21, Process Radiation Monitor Spikes Cause Control Room Ventilation and Containment Vent Isolation.

(Closed) LER 251/88-02, Containment and Control Room Ventilation Isolation Due to Personnel Error while Performing Modification to Remove a Remote Alarm Function.

(Closed) LER 250/88-03, Containment Ventilation and Control Room Ventilation Isolation While Containment Particulate Radiation Monitor Setpoint Was Being Checked.

(Closed) LER 250/88-10, Containment Ventilation and Control Room Ventilation Isolation While Containment Particulate Radiation Monitor Setpoint Was Being Checked on Two Separate Occasions.

The following corrective actions have been or will be taken in the near future. All radiation monitor drawers were replaced with new equipment and the licensee is developing modification packages to install a grounding warning alarm, a by pass/override switch for R-11/R-12 during maintenance and separate power source/breaker for R-11/R-12. The engineering package for the above modification has a target due date of August 1988. These LERs are closed.

(Closed) LER 251/87-09, Both Diesel Generators Out of Service Causing Loss of Emergency Power Supply for the Residual Heat Removal System. The event was discussed in Inspection Report 250,251/87-22. The personnel involved were counseled and the EDG was returned to service. This item is closed.

(Closed) LER 250/87-27, Transport of Containment Seal Injection Filter Causes Actuation of Process Radiation Monitor R-11 Resulting in Containment Vent and Control Room Ventilation Isolation. This event was discussed in detail in NRC Inspection Report 250,251/87-48 and resulted in a violation, 250,251/87-48-01, for failure to follow health physics procedures. This item is closed.

(Closed) LER 250/87-28, Missed Surveillance of Control Rod Positions Due to Personnel Error. The individuals involved were counseled and the licensee is reviewing methods for improving surveillance tracking. This item is closed.

(Closed) LER 251/87-24, Boric Acid Heat Tracing Circuit Number 6 Decreases to Less Than 145 Degrees. This event was documented in NRC Inspection Report 250,251/87-44 and the licensee actions to correct this problem were observed during the NRC Augmented on shift coverage. This item is closed.

(Closed) LER 250/87-25, Undocumented Surveillance of Coolant Loop Operability Due to Inadequate Procedure. Procedure 3/4-OSP-201.1, RCO Daily Logs, was revised to include a note which states: With Tav_g less than 350 degrees F, two coolant loops are required to be operable and one is required to be operating. This item is closed.

(Closed) LER 251/87-20, Unit 4 Power Reduction Due to Steam Generator 4A Feedwater Flow Control Valve (FCV 4-478) Actuator Stem Not Properly Engaged With the Control Valve Stem. This event was discussed in NRC Inspection Report 250,251/87-35, and the associated plant work orders were reviewed at that time. This item is closed.

(Closed) LER 251/87-04, Intake Cooling Water (ICW) Pump 4C Out of Service (OOS) Due to Check Valve Repair and ICW Pump 4B OOS Due to a Failed Pump Shaft Coupling. This event was discussed in detail in NRC Inspection Reports 250,251/87-06 and 250,251/87-10. This item is closed.

(Closed) LER 250/88-11, Mispositioned Diesel Oil Transfer Valve Due to Personnel Error Results in Potential Loss of Long Term Fuel Supply to Emergency Diesel Generators. This event was discussed in NRC Inspection

Report 250,251/88-11. The corrective actions for this LER will be tracked in the response to Violation 250,251/88-11-02. This item is closed.

6. Data Collection For The Performance Indicator Trial Program. (T2515/80)

The Office for Analysis and Evaluation of Operational Data issues a quarterly report on performance indicators for operating commercial nuclear power reactors. This report with the seven performance indicators is the result of the trial program. The actions required by Temporary Instruction 2515/80 are completed.

7. Survey of Licensee's Response to Selected Safety Issues. (T2515/77)

This survey was taken on the following issues; reliability of high-pressure coolant injection/reactor core isolation cooling systems, biofouling of cooling water heat exchangers and natural circulation cooldown. Discussions with the NRR contact, indicated that the Region supplied the requested information in late 1986. The actions requested by this Temporary Instruction are completed.

8. Monthly and Annual Surveillance Observation (61726/61700)

The inspectors observed TS required surveillance testing and verified: That the test procedure conformed to the requirements of the TS, that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions for operation (LCO) were met, that test results met acceptance criteria requirements and were reviewed by personnel other than the individual directing the test, that deficiencies were identified, as appropriate, and were properly reviewed and resolved by management personnel and that system restoration was adequate. For completed tests, the inspectors verified that testing frequencies were met and tests were performed by qualified individuals.

The inspections witnessed/reviewed portions of the following test activities:

4-OSP-049.1	Reactor Protection System Logic Test
0-OSP-025.1	Control Room Emergency Ventilation System Operability Test
3/4-OSP-067.1	Process Radiation Monitoring Operability Test
4-OSP-059.4	Power Range Nuclear Instrumentation Shift Checks and Daily Calibrations

Control room emergency fan failure to start

On July 14, 1988, 4-OSP-067.1, entitled Process Radiation Monitoring Operability Test, was performed in order to test Control Room Ventilation System (CRVS) damper D-22. The damper was tested satisfactorily, however, a discrepancy was noted with the emergency recirculation fans SF-1A and SF-1B. The RCO noted that SF-1B was off and SF-1A was running at the

conclusion of the test. It was not known if SF-1B started and tripped or if SF-1B failed to start. The system was left in recirculation and a PWO was submitted. The design of the system is such that the emergency filtration system is initiated by containment Phase A Isolation Signal, high radiation signal from Containment Vent radiation Monitors RD-11 or RD-12, or high radiation signal from Radiation Monitors RAD-6642 or RAD-6643. The emergency supply fan SF-1B will start upon receipt of one of these signals. If a low flow signal is present, from flow switch (FS)-6659-A, the redundant supply fan SF-1A will start automatically. In the event that both supply fans are running, SF-1B will be stopped automatically after receipt of a high flow signal from FS-6659-B.

Troubleshooting was initiated to determine the problem with SF-1B. The licensee performed O-OSP-025.1, entitled Control Room Emergency Ventilation System Operability Test, and these results were satisfactory. (SF-1B started as designed). I&C then performed Temporary Procedure (TP)-450, entitled Control Room HVAC System Calibration of FS-6659-A and 6659-B, and did not find any problems. Subsequent investigation by the system engineer revealed that TP-450 did not contain any provision to reset the high flow signal following the calibration of the switch (FS-6659-B). The licensee concluded that this is the most likely cause of SF-1B failure to start. The licensee generated an On The Spot Change (OTSC)-6015 to provide a step for resetting the high flow trip for SF-1B after calibration of FS-6659-B. The licensee also issued a standing order for the RCOs to push the high flow reset push button once per shift since there is no indication of the status for the high flow relay. Another concern noted is that O-OSP-025.1 has the operator depress the high flow reset push button prior to testing system operability. This is the reason why the system passed the operability test after the fan discrepancy was noted while performing 4-OSP-067.1. The fan was subsequently returned to service on July 16, 1988, and the reset push button is being pushed once per shift until positive indication of the system being reset is provided. The inspectors questioned the licensee concerning the operability of the CRVS. Plant Changes/Modification (PC/M) 84-026, Control Room Habitability HVAC Modifications, was implemented to satisfy the licensing commitments associated with NUREG-0737. These modifications enhanced the reliability of the system by adding redundant cables and components. The inspectors questioned the redundancy requirements for the emergency supply fans. With SF-1B inoperable, due to the high flow trip relay not being reset, a single failure could preclude the redundant fan SF-1A from starting during an emergency condition. The licensee is investigating this situation along with the reportability requirements. The results of the investigation will be reviewed by the inspectors during future inspections and will be tracked as URI 50-250,251/88-18-02.

9. Maintenance Observations (62703/62700)

Station maintenance activities of safety related systems and components were observed and reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides, industry codes and standards and in conformance with TS.

The following items were considered during this review, as appropriate: That LCOs were met while components or systems were removed from service; that approvals were obtained prior to initiating work; that activities were accomplished using approved procedures and were inspected as applicable; that procedures used were adequate to control the activity; that troubleshooting activities were controlled and repair records accurately reflected the maintenance performed; that functional testing and/or calibrations were performed prior to returning components or systems to service; that QC records were maintained; that activities were accomplished by qualified personnel; that parts and materials used were properly certified; that radiological controls were properly implemented; that QC hold points were established and observed where required; that fire prevention controls were implemented; that outside contractor force activities were controlled in accordance with the approved QA program; and that housekeeping was actively pursued.

The inspectors witnessed/reviewed portions of the following maintenance activities in progress:

- Troubleshooting A EDG breaker failure to close onto bus.
- Inspection of 3B Containment Spray pump due to high bearing temperatures.
- Testing of flanges in support of NRC Bulletin 88-05.
- Repair of 4A charging pump drain valve pin hole leak.
- Troubleshooting 4C charging pump speed control circuitry.
- Troubleshooting control room ventilation fan SF-1B circuitry.
- Repair of pin hole leak in Unit 4 CV-1510A, heater drain pump discharge tell-tale drain line.

No violations or deviations were identified within the areas inspected.

10. Engineered Safety Features Walkdown (71710)

The inspectors performed an inspection designed to verify the operability of the Control Room Ventilation System. This was accomplished by performing a complete walkdown of all accessible equipment. The following criteria were used, as appropriate, during this inspection:

- a. Systems lineup procedures match plant drawings and as built configuration.
- b. Housekeeping was adequate and appropriate levels of cleanliness are being maintained.



- c. Valves in the system are correctly installed and do not exhibit signs of gross packing leakage, bent stems, missing handwheels or improper labeling.
- d. Hangers and supports are made up properly and aligned correctly.
- e. Valves in the flow paths are in correct position as required by the applicable procedures with power available and valves were locked/lock wired as required.
- f. Local and remote position indication was compared and remote instrumentation was functional.
- g. Major system components are properly labeled.

The inspectors reviewed the following documents during the course of the inspection: O-OP-025, Control Room Ventilation System; O-OSP-025.1, Control Room Emergency Ventilation System Operability Test; Operating diagram, for Unit 3 and 4 Control Room Ventilation System, 5610-T-E-4535.

No violations or deviations were identified within the areas inspected.

11. Operational Safety Verification (71707)

The inspectors observed control room operations, reviewed applicable logs, conducted discussions with control room operators, observed shift turnovers and confirmed operability of instrumentation. The inspectors verified the operability of selected emergency systems, verified that maintenance work orders had been submitted as required and that followup and prioritization of work was accomplished. The inspectors reviewed tagout records, verified compliance with TS LCOs and verified the return to service of affected components.

By observation and direct interviews, verification was made that the physical security plan was being implemented.

Plant housekeeping/cleanliness conditions and implementation of radiological controls were observed.

Tours of the intake structure and diesel, auxiliary, control and turbine buildings were conducted to observe plant equipment conditions including potential fire hazards, fluid leaks and excessive vibrations.

The inspectors walked down accessible portions of the following safety related systems to verify operability and proper valve/switch alignment:

- A and B Emergency Diesel Generators
- Control Room Vertical Panels and Safeguards Racks
- Intake Cooling Water Structure
- 4160 Volt Buses and 480 Volt Load and Motor Control Centers



Unit 3 and 4 Feedwater Platforms
Unit 3 and 4 Condensate Storage Tank Area
Auxiliary Feedwater Area
Unit 3 and 4 Main Steam Platforms

Malfunction of Rod Position Indicator (RPI)

On July 16, 1988, at 1645, with Unit 3 in Mode 1, 100% power, a Reactor Control Operator (RCO) trainee recording RPI positions, in accordance with Operations Surveillance Procedure (OSP)-201.1 entitled RCO Daily Logs, discovered RPI G-5 to be greater than 12 steps different than other Control Bank A RPIs. A review of the dayshift RCO log readings, recorded at 0735, revealed this condition existed at that time. The Off Normal Operating Procedure (ONOP)-028, entitled Reactor Control System Malfunction, was consulted as directed by OSP-201.1. Section 5.4 of this procedure requires the operator to notify the I&C and Reactor Supervisor to investigate the RPI malfunction in order to substantiate or invalidate the RPI indication. If the RPI is determined to be inoperable, the non-indicating rod position must be determined at least once per 8 hours or thermal power must be reduced to less than 50% within 8 hours. Since 8 hours had already elapsed, a unit load reduction was commenced in accordance with General Operating Procedure (GOP) 103, entitled Power Operation to Hot Standby. A flux map was performed to determine actual rod position. The rod was verified to be aligned with other rods in the bank (228 steps) and the load reduction was stopped at 97%. The RPI was aligned and the unit was returned to 100% power.

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 and Section 5.1 and 5.3 of ANSI N18.7-1972.

Regulatory Guide 1.33, Appendix A, item 1.h, specifies that procedures should be developed for log entries. Section 5.1.2 of ANSI N18.7-1972 specifies that procedures shall be followed.

(OSP) 201.1, entitled RCO Daily Logs, Attachment 1, Item 73, Control Rod Positions, specifies that if a difference of greater than 12 steps between any two RPIs in a bank exists, then refer to ONOP-028, entitled Reactor Control System Malfunction.

Contrary to the above, on July 16, 1988, the dayshift RCO failed to refer to ONOP 028 with rod G-5, Control Bank A, indicating greater than 12 steps misaligned with other rods in the bank. Thus, the required compensatory measures were not taken in a timely manner. This item will be tracked as violation 250,251/88-18-01.



12. Physical Security (71881)

Station security activities were observed during this inspection period to ascertain that they were conducted in compliance with the approved Physical Security Plan (PSP).

The following attributes were considered during these observations, as appropriate: That the minimum number of armed guards is on site for each shift; that search equipment such as x-ray machines, metal detectors and explosives detectors are operational; that the protected area (PA) barrier is well maintained and is not compromised by erosion, opening in the fence or walls, or proximity of vehicles or other objects that could be used to scale the barrier; that illumination in the PA is adequate to allow patrolling guards to observe the area at night and permit the use of closed circuit monitors by alarm station operators; that the vital area (VA) barriers are well maintained; that persons granted access to the site are badged to indicate whether they have unescorted or escorted access authorization; that there are no obstructions in the isolation zone that could conceal an individual attempting an unauthorized entry or interference with the detection/assessment system; and that when search equipment or alarm systems are inoperable, or when there is a breach of the PA or VA barrier, the licensee implements appropriate compensatory measures.

No violations or deviations were identified within the areas inspected.

13. Plant Events (93702)

The following plant events were reviewed to determine facility status and the need for further followup action. Plant parameters were evaluated during transient response. The significance of the event was evaluated along with the performance of the appropriate safety systems and the actions taken by the licensee. The inspectors verified that required notifications were made to the NRC. Evaluations were performed relative to the need for additional NRC response to the event. Additionally, the following issues were examined, as appropriate: details regarding the cause of the event; event chronology; safety system performance; licensee compliance with approved procedures; radiological consequences, if any; and proposed corrective actions. The licensee plans to issue Licensee Event Report (LERs) on each event within 30 days following the date of occurrence.

On June 27, 1988, at 1300, with both units at 100% power, the licensee reported a significant event in that the Emergency Notification System (ENS) phone was out of service. The licensee contacted the telephone company to effect repairs and the phone was returned to service.

On July 6, 1988, with Units 3 and 4 at 100% power, Florida Power and Light Company (FPL) was notified of a confirmed positive drug screen for cocaine of 2894 nanograms/ml for an individual. This individual had unescorted access authorization to the site's protected and vital areas, and was

within the protected area at the time the test was requested. On January 8, 1988, this individual was selected for a random drug screen test in accordance with FPL's Fitness for Duty program. The test was confirmed positive on January 19, 1988, and the individual's unescorted access was revoked. On March 7, 1988, the individual was retested and the results were negative. The individual's unescorted access authorization was reinstated on March 11, 1988. On June 28, 1988, upon supervision having determined that the individual had an excessively high rate of absenteeism, the individual was requested to submit a urine sample for analysis. The results of this test were confirmed positive on July 6, 1988. The individual resigned from FPL on July 8, 1988. The individual's excessive rate of absenteeism was the cause for the request for the urinalysis. The individual's unescorted access was revoked. A review of the individual's recent work activities was performed, with no identified areas of concern.

On July 9, 1988, the licensee made a 48 hour telephone notification to the NRC concerning suspect flanges identified in response to NRC Bulletin 88-05. The licensee identified 121 flanges installed in the Unit 4 ICW/CCW Heat Exchanger Amertap System. A similar telephone notification was made July 15, 1988, concerning 24 suspect flanges found in the Steam Generator Wet Layup System. The licensee is currently evaluating data obtained from testing the subject flanges.

On July 16, 1988, at 1240, with both units at 100% power, an actuation of the PRMS containment and control room ventilation isolation system occurred. The isolation was caused by an apparent increase in Unit 4 containment airborne activity levels which was verified by a sample taken from the containment. The licensee conducted a visual inspection of the accessible areas of the containment and observed no signs of leakage. Inspection of the PRMS R-11 detector found the detector jammed against the paper. The detector was replaced and reset to the proper height (1/16") above the paper. The licensee concluded the most probable cause for the increased activity level was due to an increase in seal leakage for RCS 4B. The licensee continued to monitor RCS leak rate and containment activity levels.

On July 16, 1988, at 1645, with both units at 100% power, the RPI for Unit 3 control rod G-5 was found to indicate greater than 12 steps different than the other Bank A RPI indications. This required a forced load reduction and the performance of a flux map to verify the actual position of the control rod. The flux trace indicated the actual position of the rod was at 228 steps, the RPI was aligned, and the unit was returned to 100%. See paragraph 11 for further discussion of this issue.

14. Exit Interview

The inspection scope and findings were summarized during management interviews held throughout the reporting period with the Plant Manager - Nuclear and selected members of his staff. An exit meeting was conducted



on August 1, 1988. The areas requiring management attention were reviewed. No proprietary information was provided to the inspectors during the reporting period.

- Violation 50-250,251/88-18-01, failure to follow procedure, in that the ONOP for Reactor Control System Malfunction was not referred to with one RPI reading greater than 12 steps misaligned with other RPIs in the same bank.
- Unresolved Item (URI) 50-250,251/88-18-02, review the licensees evaluation concerning the inoperable emergency fan SF-1B for the CRVS.

15. Acronyms and Abbreviations

ADM	Administrative
a.m.	ante meridiem
ANSI	American National Standards Institute
AP	Administrative Procedures
CFR	Code of Federal Regulations
ENS	Emergency Notification System
ERT	Event Response Team
FPL	Florida Power & Light
FSAR	Final Safety Analysis Report
IEB	Inspection and Enforcement Bulletin
IFI	Inspector Followup Item
LCO	Limiting Condition for Operation
LER	Licensee Event Report
LIV	Licensee Identified Violation
MP	Maintenance Procedure
NCR	Non-conformance Report
NRC	Nuclear Regulatory Commission
ONOP	Off Normal Operating Procedure
OP	Operating Procedure
OTSC	On The Spot Change
PC/M	Plant Change/Modification
p.m.	post meridiem
PNSC	Plant Nuclear Safety Committee
PSN	Plant Supervisor Nuclear
QA	Quality Assurance
QC	Quality Control
RCO	Reactor Control Operator
SRO	Senior Reactor Operator
TS	Technical Specification
TSA	Temporary System Alternative
URI	Unresolved Item

