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 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
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 CONWAY, W.F. Florida Power & Light Co.
 RECIPIENT NAME RECIPIENT AFFILIATION
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SUBJECT: Responds violations & deviations noted in Insp Repts
 50-250/88-36 & 50-251/88-36.

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JANUARY 17 1969.

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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
and Notice of Deviation
Inspection Report 88-36

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/RHF/gp

Attachment

cc: Malcolm L. Ernst, Acting Regional Administrator,
Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

IEO1
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ATTACHMENT

RE: TURKEY POINT UNITS 3 AND 4
DOCKET NOS. 50-250 AND 50-251
IE INSPECTION REPORT 250-88-36 & 251-88-36

FINDING

10 CFR 50, Appendix B, Criterion XVI, as implemented by FPL Topical Quality Report (TQAR) 1-76-A, Topical Quality Requirement (TQR) 16.0, Corrective Action, requires that documented measures be used to assure that conditions adverse to quality, such as nonconformances, be promptly identified and corrected as soon as practicable. TQR 16.2.1, requires that where corrective action is required of contractor personnel, FPL shall require the A/E, NSSS vendor, constructor and other suppliers of safety related materials and services to have a documented corrective action system. Westinghouse Energy Systems Services Division (ESSD) procedure OPR 210-4, Control of Nonconformances, paragraphs A and B under the heading of General, states in part that NSSS components, parts, material or safety related service for which an ESSD organization is responsible shall have the responsible engineering group provide technical justification to support dispositioning of repair or accept as-is, and it shall be documented as part of the Nonconformance Report.

Contrary to the above, on October 22, 1988, when Westinghouse site personnel became aware of a potential field discrepancy regarding damage to the Unit 4 reactor vessel head, no Nonconformance Report justifying a repair was generated.

RESPONSE:

- 1) Florida Power and Light accepts the violation.
- 2) The reason for the violation was failure to follow procedural requirements. On October 22, 1988 the Unit 4 reactor vessel head was to be temporarily placed on the reactor vessel from its storage location on the reactor head stand. This work was being conducted as a radiation protection measure based on ALARA to reduce area radiation levels due to shine from the reactor vessel. While the head was being placed on the reactor vessel, it impinged on a guide stud located at position 17, causing the guide stud to be slightly bent.

The area adjacent to the stud hole where the guide stud was bent was immediately inspected by Westinghouse refueling personnel. The inspection did not reveal any apparent adjacent damage. The bent guide stud was replaced on October 23, 1988.

On October 23, 1988, the underside of the reactor vessel head in the vicinity of the guide stud was again inspected by the Westinghouse Outage Coordinator, Refueling Coordinator and Quality Control. The reinspection identified a small area of upset metal (burr) on the underside of the vessel head adjacent to the head stud hole in which the guide stud was bent. This condition was discussed in the field and FPL concurrence to remove the burr as a



precautionary measure was obtained. The upset metal was then removed using a small (1/2 inch wide by 4 inches long) hand file. The vessel head was then set on the reactor vessel.

The above actions were taken for expediency to address ALARA concerns. Removal of the upset metal was deemed prudent since it was not in a critical pressure boundary mating area and since its removal would assure there would be no further damage to the guide stud or potential damage to the reactor vessel flange during the temporary replacement of the head. Westinghouse Quality Assurance Surveillance Report number 152 was immediately written to identify and document this action. This Surveillance Report resulted in issuance of Westinghouse Nonconformance Report (NCR) number FLA-88-004 on October 24, 1988 to further identify and document the condition and actions taken.

Subsequent review indicated that the removal of the upset metal prior to initiating NCR FLA-88-004 was not in accordance with the Westinghouse Quality Assurance (QA) Manual OPR 610-3. The QA Manual requires the Field Services Coordinator to establish and maintain a "hold" on activities until problems are resolved and properly dispositioned.

- 3) The corrective steps which have been taken and the results achieved include:
- a. Westinghouse NCR FLA-88-004 was initiated to identify the condition and the actions taken. The NCR is still being evaluated, and will be dispositioned prior to placement of the vessel head for installation at the completion of this refueling outage.
 - b. Westinghouse NCR FLA-88-005 was issued on October 25, 1988 to identify the violation of the requirements of the Westinghouse QA Manual.
 - c. Senior onsite management reviewed the incident in detail at a staff meeting and the responsible FPL manager was individually counseled.
 - d. Florida Power and Light personnel involved in this incident were informed of the contents of Westinghouse NCR FLA-88-005. They were made aware of the failure to comply with QA Manual requirements.
 - e. FPL has requested that Westinghouse inform their personnel involved with this incident of the contents of, and reason for, issuance of NCR FLA-88-005, which documents the failure to comply with the requirements of the Westinghouse QA Manual.



4) Corrective steps which will be taken to avoid further violations include:

a. Westinghouse NCR FLA-88-004 is being evaluated and will be dispositioned to address the discrepant condition.

5) The date when full compliance will be achieved is:

1. The NCR documenting this condition, (FLA-88-004) and which will justify the repairs completed was issued on October 24, 1988. This NCR will be dispositioned prior to completion of the current Unit 4 refueling outage.



ATTACHMENT

RE: TURKEY POINT UNITS 3 AND 4
DOCKET NOS. 50-250 AND 50-251
IE INSPECTION REPORT 250-88-36 & 251-88-36

DEVIATION

The Final Safety Analysis Report (FSAR), Appendix 9.6A, paragraph 3.1.2(c), states in part that control valves shall be capable of isolating portions of the fire main for maintenance or repair without shutting off the entire system. Paragraph 2.4, Conformance to Branch Technical Position 9.5-1 Guidelines, Item A.4, states that the piping and valving is arranged such that a single break will not prevent the water supply from reaching a possible fire, and Item C.5, states that testing is conducted in accordance with procedures and verified by inspection and audit to demonstrate conformance to design and system readiness requirements. Test results are evaluated and acted upon.

Contrary to the above, as of October 29, 1988, no test program had been established to demonstrate conformance to design and system readiness requirements as demonstrated by the inability to isolate and repair a hole in the fire main piping.

RESPONSE:

The reason for the deviation was that the Turkey Point Fire Protection system testing program was developed in accordance with NFPA recommendations and industry standard practice. NFPA standards do not specify leak testing of post indicating or similar fire loop sectionalizing/isolation valves.

The testing program at Turkey Point consisted of annually stroking and servicing post indicator valves (PIVs) in accordance with NFPA recommendations. It also included the three year hydraulic gradient flow testing recommended in NFPA 291, which includes some sectionalizing of the system through the use of the PIVs.

To correct the condition which led to the deviation, Temporary Procedure (TP) 507 "Fire Main Post Indicator Valve Leak Test", was generated and issued on November 26, 1988. The purpose of this test procedure was to provide instructional guidance for the performance of leak testing on all PIVs in the Fire Protection Water Distribution System at Turkey Point. The test included measurement of leakage through PIVs before and after valve cycling with flow through the valve. The test was completed on December 5, 1988. Only one portion of the system could not be isolated initially, and it too was successfully isolated following stroking of the valve with flow. Since the system would be experiencing flow during an event which required isolation using the PIVs, it is reasonable to conclude that the system could have been isolated if required.



To avoid further deviations, TP 507, "Fire Main Post Indicator Valve Leak Test" will be converted to a plant procedure. The procedure will be scheduled for annual performance to assure ability of the PIVs to perform as identified in the FSAR.

Temporary Procedure 507 will be converted to a plant procedure by July 31, 1989, which is prior to its next annual performance.