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 FROM: 50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251

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 RECIPIENT AFFILIATION: Document Control Branch (Document Control Desk)

SUBJECT: Responds to violations noted in Insp Repts 50-250/89-24 & 50-251/89-24.

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L-89-283

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 89-24

Florida Power & Light Company (FPL) has reviewed the subject inspection report and pursuant to 10 CFR 2.201 the response is attached.

Very truly yours,

R. J. Acosta
for

C. O. Woody
Acting Senior Vice President - Nuclear

COW/JRH/cm

Attachment

cc: Stewart D. Ebnetter, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

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ATTACHMENT

RE: Turkey Point Units 3 and 4
Docket Numbers 50-250 and 50-251
NRC Inspection Report 89-24

FINDING:

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

O-GME-102.1, Troubleshooting and Repair Guidelines, step 3.1 requires that a PWO shall have been issued prior to commencing work and step 6.2.7 requires that all lifted leads be documented and independently verified. Steps 6.2.9 and 6.3.8 require all lifted leads be reconnected and independently verified.

O-ADM-715, Maintenance Procedure Usage, steps 5.5.2 and 5.5.3; provide instructions for independent verification of lifting and relanding leads.

1. Contrary to the above, licensee personnel failed to follow procedure 4-PMI-028.3 by proceeding to Section 6.4 of the procedure, prior to completing Section 6.3, resulting in an inadvertent drop of Rod M-8 on May 7, 1989.
2. Contrary to the above, leads to the turbine stop valve limit switches were lifted without adequate controls which resulted in a reactor trip during surveillance testing on May 5, 1989.

RESPONSE:

Example (1)

1. FPL concurs with the finding.
2. The reason for this example was inadequate communications between test personnel in the Control Room and at Motor Control Center B (MCC B). Test personnel in the Control Room had the responsibility for ensuring that test personnel at MCC B were supporting the performance of procedure 4-PMI-028.3, "RPI Hot Calibration, CRDM Stepping Test, and Rod Drop Test." However, test personnel at MCC B believed Section 6.3 was complete and advanced to Section 6.4 without direction from the Control Room test personnel. This condition resulted in the moveable coil fuse



for rod M-8 being removed while the CRDM Stepping Test was being performed on rod H-12 which led to the unexpected drop of rod M-8.

3. Corrective steps which have been taken and the results achieved include:

- a) I&C test personnel performing 4-PMI-028.3 were made aware of the miscommunications problem and were cautioned to be more attentive to precise communications.
- b) Procedures 3/4-PMI-028.3, "RPI Hot Calibration, CRDM Stepping Test, and Rod Drop Test," have been changed by adding a Caution Statement to Section 6.3 which states, "Ensure all CRDMs to be stepping tested are completed prior to proceeding to Section 6.4."

4. The corrective steps which will be taken to avoid further violations include:

A general communications policy statement will be placed in Maintenance Instruction MI-700, "Conduct of Maintenance," to formalize and standardize maintenance communications.

5. Date when full compliance will be achieved:

- a) Action item 3.a was completed on May 7, 1989.
- b) Action item 3.b was completed on June 20, 1989.
- c) Action item 4 will be completed by August 31, 1989.

Example (2)

1. FPL concurs with the finding.
2. Failure to comply with Procedures 0-GME-102.1, "Troubleshooting and Repair Guidelines," and 0-ADM-715, "Maintenance Procedure Usage," were cited by the NRC as being the cause for Example 2. Since the turbine stop valve limit switches were under the control of Backfit Construction, these procedures were not applicable to those components during this event.

The reason for this example was inadequate administrative controls. Through personnel interviews, FPL believes that work activities on the turbine stop valve limit switch terminal boxes were performed in the November 1988 time frame. The procedure governing the work being performed on the turbine stop valve limit switches at the time the limit switch leads were lifted was Backfit Construction procedure ASP-2, "Preparation of Site Procedures/Process Sheets." This procedure did not require the lifting of these leads to be documented.

3. Corrective steps which have been taken and the results achieved include:

Although the lifted lead condition was identified in May 1989, a new Backfit Construction procedure was developed to improve control of



Process Sheets and Installation Lists in early 1989. This new procedure, ASP-34, "Preparation of Process Sheets and Installation Lists," was issued on January 23, 1989 and superceded that part of ASP-2 addressing Process Sheets. This procedure describes the requirements for the control and documentation of Backfit Construction work activities and is applicable to all Safety Classifications of work performed by Backfit Construction at Turkey Point Units 3 and 4.

Subsequent to the issuance of ASP-34, an enhancement was made to specify that Process Sheets or Installation Lists are required for maintenance work that is not directly implemented on a Plant Work Order (PWO) or in accordance with an approved ASP.

4. The corrective steps which will be taken to avoid further violations include:

No further corrective actions are deemed necessary.

5. Date when full compliance will be achieved:

Action item 3 was completed on August 3, 1989.



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