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50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
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RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Responds to violations noted in Insp Repts 50-250/90-40 & 50-251/90-04.Corrective actions:task group formed to procure & implement computerized surveillance scheduling program & procedures revised to monitor RCS pressure indicators.

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JANUARY 17 1991

L-91-23
10 CFR 2.201

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

Gentlemen:

Re: Turkey Point Units 3 and 4
Docket No. 50-250 and 50-251
Reply to Notice of Violation
NRC Inspection Report 90-40

Florida Power and Light Company has reviewed the subject inspection report and pursuant to 10 CFR 2.201, the required response is attached.

Very truly yours,

J. H. Goldberg
President
Nuclear Division

JHG/DPS/ds

Attachment

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

230094

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1/1

ATTACHMENT

REPLY TO NOTICES OF VIOLATION

RE: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
NRC Inspection Report 90-40

FINDING A

Technical Specification (TS) 4.15.4.a.1 requires the fire protection hose stations in the vicinity of safety-related equipment to be visually inspected on a monthly interval. TS 4.0.1 allows the scheduled interval to be adjusted, plus or minus 25 percent, to accommodate normal test schedules.

Contrary to the above, the allotted time interval to perform TS surveillance 4.15.4.a.1 was exceeded in that between October 4, 1990, and On November 13, 1990, this monthly surveillance was not accomplished. This exceeded the TS required time including the additional 25 percent allowed by TS 4.0.1.

RESPONSE TO FINDING A

1. FPL concurs with the finding.

2. The cause for exceeding the maximum allowed TS interval between Fire Hose Station surveillances was inadequate administrative controls of the surveillances. If surveillances are performed on the date scheduled by procedure 0-OSP-200.1, the surveillances will be performed within maximum time intervals allowed by TS. If a surveillance is to be performed later than the scheduled date, Control Room personnel identify this condition during their daily review of procedure 0-OSP-200.1 scheduling sheets. They then track the surveillance to completion and ensure that it is completed within the allowable time frame. However, if a surveillance is performed earlier than scheduled by procedure 0-OSP-200.1, no guidance for controls existed at the time of this event to ensure that the maximum time interval allowed by TS is not exceeded for a subsequent surveillance test.

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

   This event and applicable corrective actions were reported in Licensee Event Report (LER) 50-250/90-022-0, submitted to the NRC on December 12, 1990. These corrective actions included the following:

a. Appendix A to procedure MP 15537.5 was satisfactorily completed on November 13, 1990. All fire hose stations were found to be operable.

b. The TS surveillance planner responsible for procedure MP 15537.5 was counselled.

c. A memorandum has been issued to plant departmental supervisors responsible for the performance of surveillances identified in procedure 0-OSP-200.1. The requirement for performing TS surveillances within the maximum time interval allowed by TS was re-emphasized.

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

On January 14, 1991, the Turkey Point Site Vice President formed a Task Force to procure and implement a computerized surveillance scheduling program. This program will be used to implement a new centralized accountability for the performance of required surveillances. The centralized accountability and the computerized surveillance scheduling program are scheduled to be implemented during the current dual unit outage.

5. Date when full compliance was achieved:

The late surveillance reported in this NOV was completed satisfactorily on November 13, 1990.

FINDING B

Technical Specification 6.8.1 requires that written procedures and administrative policies be established, implemented, and maintained in accordance with the requirements and recommendations of Appendix A of Regulatory Guide 1.33.

Appendix A of Regulatory Guide 1.33, Revision 2, dated February, 1978, recommends that written procedures be established for typical safety-related activities carried out during the operation of nuclear power plants. Section 1. b of this Appendix suggests administrative procedures which include authorities and responsibilities for safe operation and shutdown, and Section 2.j of this Appendix recommends general plant operating procedures for plant operation from Hot Standby to Cold Shutdown.

Paragraph 5.1.6 of procedure 0-ADM-200, 'Conduct of Operations,' requires all on-shift Operations personnel to be aware of and responsible for the plant status at all times.

Paragraph 5.11 of procedure 4-GOP-305, 'Hot Standby to Cold Shutdown,' requires that pressurizer pressure be maintained within

the range of 325 to 375 psi for the establishment and verification of Overpressure Mitigation System operation.

Contrary to the above, on November 26, 1990, while preparing to place the Overpressure Mitigation System into service during the Unit 4 shutdown, an operator failed to adequately monitor plant status and to maintain pressure within the required range in that pressurizer pressure reached the power operated relief valve (PORV) lift setpoint of 415 psi and PORV 4-455C inadvertently opened.

RESPONSE TO FINDING B

1. FPL concurs with the finding.

2. This event was caused by cognitive personnel error, in that a licensed plant operator failed to maintain RCS pressure within the limits of 325 psig and 375 psig as required by procedure 4-GOP-305, "Hot Standby to Cold Shutdown."

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

   Upon receipt of the Overpressure Mitigation System high pressure alert and Overpressure Mitigation System control alarms, the operator immediately reduced pressure manually to approximately 350 psig.

   The operator responsible for maintaining RCS pressure within the required range during this event has been counseled by Operations management for failure to closely monitor for pressure changes whenever pressurizer spray is changed.

4. Corrective steps which will be taken and the results achieved include:

   Procedures 3/4-GOP-305 will be revised to caution the operators to closely monitor all RCS pressure indicators to ensure that the proper pressure range is maintained. A caution will also be added to remind the operators of the small margin between the required pressure range and the PORV lift setpoint.

   The procedure revisions will be completed prior to re-establishing RCS integrity during the dual unit outage currently in progress. RCS integrity is scheduled to be re-established in Unit 3 on September 12, 1991, and Unit 4 on October 15, 1991.

5. Date when full compliance was achieved:

RCS pressure was immediately restored to within the required range upon receipt of the alarms mentioned above.