

# ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

## REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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 GOLDBERG, J.H.      Florida Power & Light Co.  
 RECIP. NAME      RECIPIENT AFFILIATION  
                          Document Control Branch (Document Control Desk)

SUBJECT: Responds to violations noted in Insp Repts 50-250/92-10 & 50-251/92-10. Corrective actions: instrument & control maint initial & continuing training programs revised to incorporate self-checking.

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JUN 26 1992

L-92-173  
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 92-10

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

If there are any questions please contact us.

Very truly yours,

J. H. Goldberg  
President Nuclear Division

JHG/JEK/jk

Attachment

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

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ATTACHMENT

REPLY TO A NOTICE OF VIOLATION

RE: Turkey Point Units 3 and 4  
Docket Nos. 50-250 and 50-251  
NRC Inspection Report 92-10

FINDING A:

Technical Specification (TS) 6.8.1 requires that written procedures be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

Section 8.b(1) of Regulatory Guide 1.33, Appendix A, Revision 2, February 1978, recommends that implementing procedures be written for each calibration listed in the TSs. Item (ff) of this paragraph specifies procedures for water storage tank level instrument calibrations.

Procedure 3-PMI-062.1, Refueling Water Storage Tank Level Instrumentation Channels LT-6583A/B Calibration, satisfies the calibration requirements of TS 4.3.3-3, Table 4.3-4, Item 20, Refueling Water Storage Tank. It provides the instructions and the necessary data to ensure proper calibration and functional testing of the process control instrumentation associated with the Refueling Water Storage Tank (RWST) level indicating system.

Contrary to the above, the licensee failed to follow procedure 3-PMI-062.1 in that during the calibration of the Unit 3, Channel B, RWST level transmitter on April 2, 1992, the Unit 4, Channel A, RWST level transmitter was removed from service instead of the Unit 3, Channel B, RWST level transmitter.

This is a Severity Level IV violation (Supplement 1).

RESPONSE TO FINDING

1. FPL concurs with the finding.
2. Cause of the violation:

The root causes of the event were a lack of attention to detail and failure to follow an approved procedure by the technician performing the work. Prior to beginning the



calibration procedure, the I&C Field Supervisor conducted a crew briefing covering the prerequisites, precautions, and limitations of the work process to be accomplished. The calibration of the racks for Channel B was completed in the morning. After lunch, the crew proceeded to calibrate the level transmitter. One technician went to the instrument racks to measure voltage while the other technician went to the transmitter in the field. The technician at the instrument rack and the technician at the transmitter each had a copy of the procedure in hand while performing the calibration. The technician at the transmitter proceeded to the wrong transmitter and removed it from service. Upon receiving the low level alarm in the control room, the Reactor Control Operator paged the I&C technician and notified him of the error.

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

1. Upon notification of isolating the wrong transmitter, the technician returned the transmitter to service under the direction of the Field Supervisor. The channel was immediately returned to service.
2. The technician was counselled on the need to use self checking techniques even when using procedures. The technician was also disciplined in accordance with FPL Nuclear Division policy. This policy provides additional emphasis as to the impact of an error of this type.

4. The corrective steps taken to avoid further violations:

The Instrument and Control Maintenance Initial and Continuing Training Programs have been revised to incorporate self checking.

5. The date when full compliance was achieved:

Full compliance was achieved on April 2, 1992 with the return to service of the Unit 4 Channel A, RWST level transmitter.

FINDING B:

TS 6.8.1 requires written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, and Sections 5.1 and 5.3 of ANSI N18.7-1972.

Paragraph 3 of Regulatory Guide 1.33, Appendix A, Revision 2, February 1978, recommends the establishment of procedures for the operation of safety-related systems.





Section 5.1.2 of ANSI N18.7-1972 requires that procedures be followed.

Procedure 0-ADM-201, Upgrade Operations Procedure Usage, paragraph 5.1, Procedural Adherence Policy, states in part that procedures shall be present during performance of tasks for which verification is documented by initial or signature.

Procedure 3-OP-072, Main Steam System, paragraphs 7.1 and 7.2, define the steps required to place the Main Steam Isolation Valve backup nitrogen bottles in service and/or in standby. These steps require initials for operator and second verification.

Contrary to the above, on April 20, 1992, a turbine operator replaced the in-service Unit 3 A and B main steam isolation valve backup-nitrogen bottles with standby backup-nitrogen bottles without following the procedure and without the required second verification. This resulted in the misalignment of valves and isolation of the nitrogen backup system for the 3A and B main steam isolation valves.

This is a Severity Level IV violation (Supplement 1).

#### RESPONSE TO FINDING

1. FPL concurs with the finding.
2. Cause of the violation:

The root cause of this event was a cognitive personnel error by licensed and non-licensed personnel. A procedure was in place for the performance of the task of changing compressed gas nitrogen bottles for the backup nitrogen gas system on the Unit 3 main steam isolation valves. The procedure required initials for each step and an independent verification. The procedure was not used because the non-licensed operator and his supervisor believed that the changing of the bottles was a routine operation and therefore did not require the use of a procedure. This belief was contrary to plant policy which dictates the use of a procedure when independent verification is required.

3. Corrective steps which have been taken and the results achieved:
  1. The A and B main steam isolation valves were returned to service by realigning the backup compressed gas nitrogen bottles in accordance with procedures as soon as the valve misalignment was identified. This action restored operability to the A and B main steam isolation valves in

accordance with the Technical Specification requirements.

2. The following safety related systems for both Units 3 and 4 were walked down by the system engineers or operations personnel for alignment verification in accordance with the appropriate system alignment verification procedures:

- Intake Cooling Water
- Component Cooling Water
- Boric Acid System
- Post Accident Containment Vent System
- Containment Spray
- Auxiliary Feed Water
- High Head Safety Injection
- Residual Heat Removal System
- 125 Volt Vital DC
- Startup Transformer
- Onsite AC Distribution
- Post-accident Hydrogen Monitoring System

No other incorrect valve or breaker alignments were found.

3. The non-licensed operator and his licensed supervisor were disciplined in accordance with FPL Nuclear Division policy. This policy provides additional emphasis as to the unacceptability of not using a procedure written specifically for a task.
4. The activities of the non-licensed operator during the mid-shift of April 20, 1992, were reviewed. No other anomalies were noted.
4. The corrective steps taken to avoid further violations:  
  
Each operations crew, including both licensed and non-licensed operators, met with plant upper management to reinforce the necessity and requirement to use procedures with verbatim compliance on safety related systems when performing even the most routine operation. Procedure use is required when step signoffs are required. The details of this event and procedure use were the focus of these meetings.
5. The date when full compliance was achieved:  
  
Full compliance was achieved on April 20, 1992 with the return to service of the Unit 3 A and B main steam isolation valves.

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