UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

Report Nos.: 50-250/95-14 and 50-251/95-14

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 Units 3 and 4

Inspection Conducted: July 2 through 29, 1995

Inspectors: T. P. Johnson 8/10/95
T. P. Johnson, Senior Resident Inspector — Date Signed

B. B. Desai, Resident Inspector

Approved by: K. D. Landis 8/11/95
K. D. Landis, Chief — Date Signed
Reactor Projects Section 2B
Division of Reactor Projects

SUMMARY

Scope:

This resident inspection was performed to assure public health and safety, and it involved direct inspection at the site in the following areas: plant operations including operational safety, refueling preparations, and plant events; maintenance including surveillance observations; engineering; and plant support including radiological controls, chemistry, fire protection, and housekeeping. Backshift inspections were performed in accordance with Nuclear Regulatory Commission inspection guidance.

Results:

Within the scope of this inspection, the inspectors determined that the licensee continued to demonstrate satisfactory performance to ensure safe plant operations. The inspectors did not identify any regulatory compliance issues. However, the following unresolved item was identified:

Unresolved Item 50-250/95-14-01, Pressurizer Pressure Transmitters Calibration (section 5.2.4).

During this inspection period, the inspectors had comments in the following functional areas:

Plant Operations

During the period, the licensee demonstrated effective self-assessment programs (section 4.2.1). Good management oversight associated with the self-contained breathing apparatus program was noted (section 4.2.2). Good teamwork and controls were noted during Unit 3 new fuel receipt inspections and handling (section 4.2.3).

Maintenance

Inspector-observed station maintenance and surveillance testing activities were well performed (sections 5.2.1 and 5.2.2). Miscommunications between operations and chemistry resulted in a late Unit 3 containment air sample (section 5.2.3). A licensee identified problem with the calibration of the Unit 3 pressurizer pressure protection instruments is unresolved (section 5.2.4). A relay wiring issue with the C auxiliary feedwater system was appropriately identified, evaluated, and corrected. Operability was unaffected (section 5.2.5).

Engineering

Relative to the Unit 3 pressurizer pressure calibration issue, the licensee demonstrated an effective operating experience feedback program (section 5.2.4). Strong teamwork was noted during the testing and turnover phases of the B standby steam generator feedwater pump modification (section 6.2.1). A license event report associated with the emergency load sequencers and the 480 volt load centers was timely and well written, and is therefore closed (section 6.2.2).

Plant Support

The fire protection program continued to demonstrate strong and effective performance (section 7.2.1). A security event was appropriately logged (section 7.2.2). The licensee's fire brigade response to observed smoke in the 3B motor control center was timely and appropriate. Further, the licensee's investigation into a breaker failure and smoke detector issues was thorough (section 7.2.3).

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REPORT DETAILS

1.0 Persons Contacted

1.1 Licensee Employees

T. V. Abbatiello, Site Quality Manager
R. J. Acosta, Company Nuclear Review Board Chairman
J. C. Balaguero, Technical Department Supervisor
* P. M. Banaszak, Electrical/I&C Section Supervisor
W. H. Bohlke, Vice President, Engineering and Licensing
M. J. Bowskill, Reactor Engineering Supervisor
* R. J. Earl, Quality Control Supervisor
J. E. Geiger, Vice President, Nuclear Assurance
J. H. Goldberg, President, Nuclear Division
* R. G. Heisterman, Maintenance Manager
* P. C. Higgins, Outage Manager
G. E. Hollinger, Training Manager
* R. J. Hovey, Assistant to the Site Vice-President
M. P. Huba, Procurement Supervisor
* D. E. Jernigan, Plant General Manager
H. H. Johnson, Operations Manager
M. D. Jurmain, Electrical Maintenance Supervisor
V. A. Kaminskas, Services Manager
T. F. King, Acting Fire Protection/Safety Supervisor
* J. E. Knorr, Regulatory Compliance Analyst
T. J. Koschmeder, Acting Instrumentation and Controls Maintenance Supervisor
* R. S. Kundalkar, Engineering Manager
J. D. Lindsay, Health Physics Supervisor
F. E. Marcussen, Security Supervisor
D. D. Miller, Acting Projects Supervisor
H. N. Paduano, Manager, Licensing and Special Projects
* T. F. Plunkett, Site Vice President
* R. E. Rose, Nuclear Materials Manager
A. M. Singer, Operations Supervisor
R. N. Steinke, Chemistry Supervisor
D. J. Tomaszewski, Acting Technical Manager
B. C. Waldrep, Mechanical Maintenance Supervisor
* E. J. Weinkam, Licensing Manager

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

1.2 NRC Resident Inspectors

* B. B. Desai, Resident Inspector
* T. P. Johnson, Senior Resident Inspector

* Attended exit interview (Refer to section 8.0 for additional information.)

Note: An alphabetical tabulation of acronyms used in this report is listed in section 9.0 of this report.

2.0 Other NRC Inspections Performed During This Period

Report No.	Dates	Area Inspected
50-250,251/95-13	July 19-21, 1995	Chemistry Van/Confirmatory Measurements

3.0 Plant Status

3.1 Unit 3

At the beginning of this reporting period, Unit 3 was operating at full reactor power and had been on line since April 9, 1995. The unit operated at full power during the report period.

3.2 Unit 4

At the beginning of this reporting period, Unit 4 was operating at full reactor power and had been on line since March 12, 1995. The unit operated at full power during the report period.

3.3 Common

On July 21, 1995, the plant set a record for dual unit run of greater than 102 days.

4.0 Plant Operations (40500, 60705, and 71707)

4.1 Inspection Scope

The inspectors verified that the licensee operated the facilities safely and in conformance with regulatory requirements. The inspectors accomplished this by direct observation of activities, tours of the facilities, interviews and discussions with personnel, independent verification of safety system status and technical specification compliance, review of facility records, refueling preparations, and evaluation of the licensee's management control.

The inspectors also performed a review of the licensee's self-assessment capability by including PNSC and CNRB activities, QA/QC audits and reviews, line management self-assessments, individual self-checking techniques, and performance indicators.

4.2 Inspection Findings

4.2.1 Self-Assessment Activities

During the period, the inspectors reviewed licensee self-assessment activities. This included the following: several PNSC meetings; the July 26, 1995, PTN status meeting; the July 18, 1995, CNRB meeting; QA/QC independent activities; and line management initiated reviews. The inspectors noted the on-site presence of FPL corporate management at the CNRB and the PTN Status Meetings The inspectors also noted that line management and independent reviews and assessments were self-critical and demonstrated conservative operation of the nuclear units. CNRB members demonstrated a good questioning attitude and a strong safety perspective. The reviews and self-assessments recognized current plant issues and the current trend of performance. In summary, the inspectors concluded that FPL has effective programs relative to self-assessment which ensured nuclear safety.

4.2.2 Self-Contained Breathing Apparatus Programs

The inspectors reviewed licensee procedures and practices associated with SCBA programs. The licensee's SCBA program procedure 0-ADM-041, PTN Respiratory Protection Plan, states that the need for SCBA use at Turkey Point is to limit inhalation of harmful atmospheres including airborne radiological contaminants; non-radiological hazards during planned activities such as spray painting, abrasive blasting, solvent/cleaning, welding, etc.; and oxygen deficient environments. SCBAs are also utilized by the fire team while carrying out fire brigade functions.

The licensee does not have provisions for SCBA use (including in the control room) following an unplanned toxic gas release in the vicinity of the plant. The basis for this is that no potential toxic chemical releases have been identified for the site. The inspectors discussed the issue with the licensee and verified the bases in UFSAR section 9.9.1.3, Control Room Emergency Operation Design. The inspector also recently reviewed the SCBA program as documented in NRC Inspection Report 50-250,251/95-11. The inspector concluded that the licensee has a good SCBA program with strong management oversight.

4.2.3 Unit 3 New Fuel Receipt

During the period, the licensee received shipments of new fuel for the upcoming Unit 3 refueling outage. The shipping containers were unloaded, moved, and opened. The new fuel was unloaded, inspected, and moved to the new fuel storage racks. The licensee used procedures 0-OSP-040.11, Receipt of New Fuel and 0-OP-040.1, Handling New Fuel Shipping Containers and New Fuel Assemblies.

The inspector reviewed the procedures, observed the new fuel receipt activities, and discussed these activities with licensee personnel. The inspector noted good teamwork among operations, reactor engineering, and maintenance personnel, and good support by HP, Security, and QC personnel. Activities were well controlled and performed in accordance with procedures.

5.0 Maintenance (61726 and 62703)

5.1 Inspection Scope

The inspectors verified that station maintenance and surveillance testing activities associated with safety-related systems and components were conducted in accordance with approved procedures, regulatory guides, industry codes and standards, and the technical specifications. They accomplished this by observing maintenance and surveillance testing activities, performing detailed technical procedure reviews, and reviewing completed maintenance and surveillance documents.

5.2 Inspection Findings

5.2.1 Maintenance Activities Witnessed

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

- Unit 3 new fuel receipt (section 4.2.2), and

- C AFW pump and turbine maintenance (section 5.2.5).

For those maintenance activities observed, the inspectors determined that the activities were conducted in a satisfactory manner and that the work was properly performed in accordance with approved maintenance work orders.

5.2.2 Surveillance Testing Activities Observed

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

- procedure 3-SMI-41.10, Pressurizer Pressure Protection Loops Monthly Analog test (section 5.2.4),

- procedure TP-1167, Diesel Driven Standby Steam Generator Feedwater Pump Start-up Test (section 6.2.1), and

- procedure 4-OSP-200.3, Secondary Plant Periodic Test.

The inspectors determined that the above testing activities were well performed and met the requirements of the technical specifications.

5.2.3 Reactor Coolant System Leakage Surveillance

On July 5, 1995, at about 2:15 p.m., the Unit 3 containment atmosphere process radiation monitors (RD-3-11 and 12) were removed from service due to a noisy sample pump. Technical Specification 3.4.6.1 was appropriately entered which required the following:

- 7-day action statement,
- containment sump level monitoring system operability verification,
- containment 24-hour grab sample and analysis,
- 8-hour RCS water inventory balance, and
- closure of the containment purge, exhaust, and air bleed valves.

The licensee initiated actions to perform these above requirements as well as to repair the sample pump. At about noon on July 6, 1995, the chemistry department and operations began actions for the 24-hour containment grab sample. However, due to a miscommunication, a clearance was hung which isolated the alternate sample path. This action delayed the sample and analysis by 34 minutes. The licensee subsequently entered a 6-hour LCO, which was exited when the sample was analyzed. No radioactivity was detected in the sample. The licensee initiated a condition report (No. 95-546) and performed the following number of corrective actions.

The inspector reviewed this issue including the condition report, the LCO, operator logs, and discussed the issue with chemistry, operations, and management personnel. The inspector reviewed the current NRC guidance relative to surveillance interval grace of ± 25% per Technical Specification 4.0.2. This included standard technical specifications, NUREG 1433, and a draft technical guidance document. The inspector also discussed the issue with NRR. The licensee concluded, and the resident inspectors agreed, that the licensee met technical specification 3.4.6.1 LCO action statement when they entered and subsequently exited the 6-hour action to hot standby.

The inspector concluded that the licensee appropriately documented, reported, and corrected this miscommunication issue between chemistry and operations concerning the sample. Further, the inspector concluded that no violations of technical specifications occurred. However, the licensee should review their current Technical Specification 4.0.2 requirements and interpretations to ensure they are appropriately understood and addressed.

5.2.4 Pressurizer Pressure Transmitter Calibration

Based on a recent problem at another PWR, the licensee's technical department and system engineering performed an operating experience feedback review per FOP-042 as documented on condition report No. 95-528. The problem was associated with calibration errors with the pressurizer pressure protection transmitters. The licensee determined that the same problem did not exist at Turkey Point. However, a different calibration issue for the Unit 3 pressurizer pressure protection channels (PT-455, 456, and 457) was identified. Routine refueling calibrations of these pressurizer pressure channels performed in April 1994 were done with a Heise gauge which was later found to have about a 15-20 psig error (low).

The licensee immediately documented this calibration issue in another condition report (No. 95-550) and performed an operability and reportability assessment. A review of the Unit 3 control room pressurizer pressure protection channels noted them to be 10 to 20 psig higher than both the Unit 3 control channels and the corresponding Unit 4 pressure channels. (One graduation of the control room pressure instrument is 20 psig). Further, the licensee reviewed the calibrations performed in April 1994 (procedures 3-PMI-041.69, .70, and .71, Pressurizer Pressure Protection Calibration) noting that the as-found values were all low, requiring an adjustment. This could be indicative of a Heise gauge calibration problem. The Heise gauge was successfully calibrated by the M&TE shop on January 25, 1994. However, due to an apparent damaged gauge, noted after the April 1994 pressurizer pressure calibrations, the M&TE shop put a hold on further use and on June 16, 1994, found the gauge to be out-of-calibration by about 15 to 20 psig. Based on the damage to the Heise gauge occurring after the April 1994 calibrations, the licensee concluded the Unit 3 pressurizer pressure channels had been satisfactorily calibrated. This M&TE assessment was completed in June 1994.

Engineering performed an evaluation and supporting calculations (PTN-3FJI-95-005) to review this issue. The licensee concluded that the reactor protection and SI functions performed by pressurizer pressure (e.g., low/high pressurizer pressure reactor trip, low pressure SI, and OTΔT reactor trip) remained operable. The licensee concluded that the low pressure reactor trip was the most limiting item due to Technical Specification Table 2.2-1 five column format for allowable errors and the trip setpoints.

The nominal reactor trip setpoint for low pressurizer pressure is 1835 psig with an allowable value of 1817 psig and an allowable tolerance of 4.5% of span (1000 psig) or an error of 45 psig. Thus, the safety analysis trip setpoint of 1790 psig would be assured. This allowable tolerance is comprised of rack errors, sensor errors, and other errors, all based on Westinghouse methodology and Technical Specification equation 2.2-1. The licensee reviewed of the current cycle monthly surveillances which check the trip setpoints (per procedure 3-SMI-41.10, Pressurizer Pressure Protection Loops Monthly Analog Test) noting that all of the results were within the test acceptance criteria of ± 10mv or 2.5 psig. Thus the instrument rack error was no more that 2.5 psig. Thus, given the current higher than expected sensor error and the as measured rack error, the licensee concluded that Technical Specification 2.2.1 and equation 2.2-1 were met.

The licensee performed reviews by design and system engineering, maintenance, operations, and an independent HPES review. Corrective actions included the following:

- M&TE program enhancements,
- I&C calibration process enhancements when as-found data is out-of-specification,
- HPES independent review including root cause analysis,
- changed the monthly surveillance test acceptance criteria to ensure trip setpoints do not deviate by more than ± 12 mv (or 3.0 psig),
- calibration of the 3 PTs scheduled during the September 1995 refueling, including determination of the as-found setpoints,
- training of the I&C and M&TE personnel of the lessons learned, and
- PNSC review and approval of the condition report.

The inspectors were notified of this issue by system engineering personnel. The inspectors reviewed the condition reports, operability determinations, associated surveillance procedures, M&TE documentation, and related calibration sheets. The inspectors did not identify any issues with the licensee's operability assessment. The inspectors also discussed this item with licensee personnel. Pending the determination of the as-found calibration data scheduled for September 1995 and completion of the above corrective actions, this item is unresolved (URI 50-250/95-14-01, Pressurizer Pressure Transmitters Calibration). Further, the inspector noted the licensee's Operating Experience Feedback program to be effectively functioning by the identification of this issue.

5.2.5 Auxiliary Feedwater Wiring Error

During routine C AFW pump and turbine maintenance on July 17, 1995, licensee personnel, upon opening cabinet C240, noted that the 7CR relay was installed incorrectly. This relay is used to bypass the thermal overloads for the trip and throttle valve (MOV-6459C), during an AFW initiation sequence. The thermal overload relays ensure that the motor is protected against operating conditions that exceed design limits. With the 7CR relay pins in the incorrect socket locations, the relay coil was isolated from any power source. This configuration effectively disabled the thermal overload bypass function. Licensee calculation PTN-BF-JE-92-028 resized (oversized) the thermal overload relays for all the AFW trip and throttle MOV circuits. Maintenance inspection confirmed that the correct thermal overloads were installed. The licensee concluded that the upsized thermal overload relays met the intent of NRC Regulatory Guide 1.106, Thermal Overload Protection For Electric Motors and Motor-Operated-Valves, and of their MOV Program. The bypass relays were therefore not required for AFW pump operability. Further, the licensee concluded that the relay misalignment did not create any short circuit conditions in the AFW control circuit. Therefore, the licensee concluded that operability of C AFW pump was unaffected by this event. In accordance with existing design documents, the 7CR was properly installed prior to returning the C AFW back to service. Also, possible misalignment of the 7CR relay on the A or B AFW pumps would not have posed an operability concern for the same reasons described above.

The inspector reviewed this issue including the condition report (No. 95-561), electrical drawings, design bases, and related documentation. The inspector concluded that the licensee appropriately identified, reviewed, evaluated, and corrected this item. Further, corrective actions addressing the incorrectly installed 7CR relay were aggressive. No violations or operability issues were identified.

6.0 Engineering (37551, 90712, 90713, 92700, and 92903)

6.1 Inspection Scope

The inspectors verified that licensee engineering problems and incidents were properly reviewed and assessed for root cause determination and corrective actions. They accomplish this by ensuring that the licensee's processes included the identification, resolution, and prevention of problems and the evaluation of the self-assessment and control program.

The inspectors reviewed selected PC/Ms including the applicable safety evaluation, in-field walkdowns, as-built drawings, associated procedure changes and training, modification testing, and changes to maintenance programs.

The inspectors also reviewed the reports discussed below. The inspectors verified that reporting requirements had been met, root cause analysis was performed, corrective actions appeared appropriate, and generic applicability had been considered. When applicable, the criteria of NUREG-1600, General Statement of Policy and Procedures for NRC Enforcement Actions, were applied.

6.2 Inspection Findings

6.2.1 Standby Steam Generator Feedwater Pump Modifications

During the period, the licensee completed PC/M 94-059 which replaced the motor driver with a diesel engine driver for the B S/B SGFP. This PC/M allows the licensee to eliminate the five blackstart diesels (non-safety-related) which provide backup power to the 3C and 4C 4KV non-vital buses. Buses 3C and 4C provided the power to the A and B S/B SGFP motors, respectively. The A S/B SGFP power supply remains unchanged.

The NRC had previously approved this modification per Technical Specification amendments 164 (Unit 3) and 158 (Unit 4) in a letter and safety evaluation dated May 20, 1994. The licensee had requested this amendment in a letter dated September 3, 1993 (L-93-200). The Technical Specification 3/4.7.1.6 and related bases were modified.

The licensee completed testing and the PNSC reviewed and approved test results on July 11, 1995. The PC/M paperwork closure was completed on July 13, 1995. The licensee reported the completion of this PC/M in a letter (L-95-208) dated July 18, 1995.

The inspectors observed portions of PC/M during this inspection and also during NRC Inspection Report 50-250,251/95-10 (section 6.2.2). During the current period, the licensee experienced some delays due to diesel-pump alignment problems. The licensee worked with the vendor and replaced the diesel engine support channel. Alignment attempts were successful and testing was performed per procedure TP-1167, Diesel Driven Standby Steam Generator Feedwater Pump Start-up Test. The inspectors observed portions of the testing including the uncoupled and coupled diesel tests, and the pump IST. Testing was completed successfully. The inspectors also reviewed the completed PC/M package and turnover documentation.

During the post-modification testing, the inspectors noted strong teamwork among system and design engineering, maintenance, operations, and vendor personnel. The inspectors concluded that the licensee appropriately planned, performed, and tested the B S/B SGFP PC/M.

6.2.2 Licensee Event Report Review

The inspector reviewed LER 50-250,251/94-05-02, Design Defect in Safeguards Bus Sequencer Test Logic Places Both Units Outside Design Basis, that was issued on July 17, 1995. This LER was a revision to a previously issued LER. This revision incorporated 480 volt load center feeder breaker automatic closure vulnerability that was identified by the licensee during the verification and validation of modifications associated with the corrective actions for the original sequencer defect. This condition was reported to the NRC on June 19, 1995 in accordance with 10 CFR 50.72(b)(2)(iii). The inspectors also reviewed and discussed the condition in NRC Inspection Report 50-250,251/95-11. The licensee concluded that the affected load centers remained operable and that core cooling and ECCS requirements of 10 CFR 50.46 as well as UFSAR commitments were met contingent on manual operator actions.

The licensee has plans to modify the emergency load sequencers during the upcoming Unit 3 and Unit 4 refueling outages. This modification will correct the identified defects, including the 480 load center breaker auto closure vulnerability. The inspector plans to follow licensee corrective actions, including planned modifications. Further, this issue is being tracked through VIO 50-250,251/94-23-03, which remains open.

The inspector concluded that the LER was well written with sufficient details. LER 50-250,251/94-05-02 is considered closed.

6.2.3 Monthly Operating Report

The inspectors reviewed the June 1995 monthly operating report and determined it to be complete and accurate.

7.0 Plant Support (71750 and 64704)

7.1 Inspection Scope

The inspectors verified the licensee's appropriate implementation of the physical security plan; radiological controls; the fire protection program; the fitness-for-duty program; the chemistry programs; emergency preparedness; plant housekeeping/cleanliness conditions; and the radiological effluent, waste treatment, and environmental monitoring programs.

7.2 Inspection Findings

7.2.1 Fire Brigade Program

The inspectors reviewed the licensee's fire brigade program as described in procedure 0-ADM-016.2, Fire Brigade Program as well

as discussed its implementation with the licensee. The following program attributes were noted:

- The fire brigade is composed of a minimum of five individuals: three operators (including possible representation from the NWE and the non-licensed SNPO, NPO and ANPO); and two HP technicians. The fire brigade manning is similar during backshifts and weekends;

- The fire brigade would normally be activated following confirmation of smoke and/or flames;

- The fire alarm in the control room is audible and visible including during other annunciations such as during a reactor trip or LOOP;

- The fire brigade is trained to combat electrical switchgear fires with water fog after de-energizing equipment. Special nozzles suited for electrical fires are available in the vicinity of the switchgear areas;

- The fire brigade was tested 21 and 19 times during backshift in 1994 and 1993, respectively;

- The criteria for classifying an emergency per procedure EPIP 20101, Duties of the Emergency Coordinator are as follows: NOUE for an uncontrolled fire within the power block lasting longer 10 minutes; Alert for an uncontrolled fire potentially affecting safety systems and offsite support required; Site Area Emergency for a fire which prevents a safety system from performing its design function; and General Emergency for a major fire which has caused massive damage to plant systems resulting in any of the other General Emergency initiating conditions; and,

- Offsite assistance is requested at the discretion of the fire brigade leader and the NPS.

The inspector concluded that the licensee continued to maintain a strong and effective fire protection program.

7.2.2 Security Loggable Event

On July 21, 1995, the licensee discovered that an individual was granted temporary unescorted access on September 19, 1994, without the individual's fingerprint cards being appropriately processed. The individual was a temporary FPL employee and was on-site between the periods of September 23, 1994, through November 6, 1994, in support of the Unit 4 refueling outage.

Upon discovery, the licensee verified through the local police department that the individual did not have any criminal history.

Further, the licensee verified that all other access processing requirements were completed. The licensee determined this to be a loggable security event. Upgrades to the access authorization process are planned by the licensee to prevent recurrence.

The inspector discussed the issue with the licensee as well as the NRC regional security specialist. A security inspection is planned in the near future. The security specialist plans to review this event. The inspector concluded that the licensee appropriately determined this to be a loggable event.

7.2.3 3B Motor Control Center Room Smoke

On Saturday July 1, 1995, at 9:20 a.m., the NPO noted smoke in the 3B MCC room. The NPO called the control room and the fire team was activated. Operators entered procedures EPIP-20101, Duties of the Emergency Coordinator and 0-ONOP-016.10, Pre-Fire Plan Guidelines and Safe Shutdown Manual Actions. The NPO on the scene was also the fire team leader. The NPO and the ANPS (who also went to the scene) determined the problem to be in a non-vital breaker (30690) for the sewage pump, and subsequently opened the breaker. This action stopped the smoke generation and no actual fire occurred. The fire brigade responded appropriately and remained on location in standby.

The licensee initiated a condition report (No. 95-540), a fire incident report, and made notifications per procedure 0-ADM-115, Notifications of Plan Events. This event did not meet any formal NRC notification requirements; however, the resident inspector was called at home. Licensee personnel noted that the four installed smoke detectors did not alarm during this event. A review concluded the smoke level in the 3B MCC room was below instrument sensitivity. This was confirmed by discussions with the personnel on the scene and with the vendor. The vendor recommended verifying detector sensitivity per procedure 0-PME-091, Outside Containment Smoke Detector Sensitivity Check and Calibration.

The licensee's investigation noted that a security guard and a periodic fire watch had been in room less than 10 minutes before the NPO entered the room. These two individuals did not note any smoke; however, they did note a musty smell and alerted the NPO to check the room.

The licensee's electrical department initiated troubleshooting of the 30690 breaker. They determined that the 480/120 VAC control transformer and starter coil had shorted, and were the cause of the smoke. Repairs were completed and the breaker was returned to service.

The inspectors walked down the 3B MCC room area, inspected the faulty breaker, reviewed the related documentation and interviewed the fire team leader. The inspectors also discussed this event

with plant management and the fire protection supervisor. The inspectors concluded that the fire brigade responded promptly and appropriately. Further, the licensee's investigation into the smoke, the breaker failure, and the fire detection issues was thorough and demonstrated effective corrective programs.

8.0 Exit Interview

The inspection scope and findings were summarized during management interviews held throughout the reporting period with both the site vice president and plant general manager and selected members of their staff. An exit meeting was conducted on July 27, 1995. (Refer to section 1.0 for exit meeting attendees.) The areas requiring management attention were reviewed. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection. Dissenting comments were not received from the licensee. The inspectors did not identify any regulatory compliance issues. However, the inspectors had the following finding(s):

Item Number	Status, Description, and Reference
50-250,251/95-14-01	URI, Pressurizer Pressure Transmitter Calibration (section 5.2.4).

Additionally, the following previous items were discussed:

Item Number	Status, Description, and Reference
50-250,251/94-23-03	(Open) VIO, Inoperable Emergency Load Sequencers (section 6.2.2)
50-250,251/94-05-02	(Closed) LER - Design Defect in Safeguards Bus Sequencer Test Logic Places Both Units outside the Design Basis (section 6.2.2).

9.0 Acronyms and Abbreviations

AC	Alternating Current
ADM	Administrative
AFW	Auxiliary Feedwater
ANPO	Assistant Nuclear Plant Operator
CFR	Code of Federal Regulations
CNRB	Company Nuclear Review Board
ECCS	Emergency Core Cooling Systems
EPIP	Emergency Plan Implementing Procedure
FPL	Florida Power and Light
FL	Florida
FOP	Feedback Operating Programs
HP	Health Physics
HPES	Human Performance Evaluation System
I&C	Instrumentation and Control
IST	Inservice Test

KV	Kilovolt
L	Letter (licensing)
LCO	Limiting Condition for Operation
LER	Licensee Event Report
LOOP	Loss of Off-Site Power
M&TE	Measuring and Test Equipment
MCC	Motor Control Center
MOV	Motor-Operated Valve
mv	Milli Volts
NOUE	Notice of Unusual Event
NPO	Nuclear Plant Operator
NPS	Nuclear Plant Supervisor
NRC	Nuclear Regulatory Commission
NRR	Nuclear Reactor Regulation
ONOP	Off-Normal Operating Procedure
OP	Operating Procedure
OSP	Operations Surveillance Procedure
OTΔT	Over-Temperature-Differential Temperature
PC/M	Plant Change/Modification
PME	Preventive Maintenance - Electrical
PMI	Preventive Maintenance - I&C
PNSC	Plant Nuclear Safety Committee
psig	Pounds Per Square Inch Gauge
PT	Pressure Transmitter
PTN	Project Turkey Nuclear
PWR	Pressurized Water Reactor
QA	Quality Assurance
QC	Quality Control
RCS	Reactor Coolant System
RD	Radiation Detector
S/B SGFP	Standby Steam Generator Feedwater Pump
SCBA	Self Contained Breathing Apparatus
SI	Safety Injection
SMI	Surveillance Maintenance - I&C
SNPO	Senior Nuclear Plant Operator
TP	Temporary Procedure
UFSAR	Updated Final Safety Analysis Report
URI	Unresolved Item
VAC	Volts Alternating Current
VIO	Violation