

UNITED STATES NUCLEAR REGULATORY COMMISSION

REGION II 101 MARIETTA STREET, N.W. ATLANTA, GEORGIA 30303

Report Nos. 50-250/82-24 and 50-251/82-24

Licensee: Florida Power & Light Company

9250 West Flagler Street

Miami, FL 33101

Facility Name: Turkey Point 3 and 4

Docket Nos. 50-250 and 50-251

License Nos. DPR-31 and DPR-41

Inspection at Turkey Point site near Homestead, Florida

Inspectors:

R. J. Vogt-Lowel

7/23/82 Date Signed

Accompanying Personnel: J. A. Agles

Approved by:

C Julian, Section Chief, Division of Project

and Resident Programs

Date Signed

SUMMARY

Inspection on May 26 - June 25, 1982

Areas Inspected

This routine, announced inspection involved 175 resident inspector-hours on site in the areas of followup on licensee actions on previous inspection findings; LER review; plant operations; surveillance test observation; and plant tours.

Results

Of the five areas inspected, no violations or deviations were identified in three areas; two violations were found in two area (Violation - Inadequate corrective action allowed recurrence of a reportable condition - paragraph 5; violation - failure to adhere to RWP requirements - paragraph 6)

DETAILS

1. Persons Contacted

Licensee Employees

*J. P. Mendieta, Maintenance Superintendent Nuclear

D. W. Haase, Operations Superintendent - Nuclear

J. P. Lowman, Assistant Superintendent Mechanical Maintenance - Nuclear

L. L. Thomas, Assistant Superintendent Mechanical Maintenance

W. R. Williams, Assistant Superintendent Electrical Maintenance - Nuclear

J. W. Kappes, Instrumentation and Control Supervisor

V. B. Wager, Operations Supervisor

A. E. Byrnes, Auxiliary Building Supervisor

K. E. Beatty, Training Supervisor J. S. Wade, Chemistry Supervisor

*P. W. Hughes, Health Physics Supervisor

*D. W. Jones, Quality Control Supervisor K. N. York, Document Control Supervisor

*J. A. Labarraque, Technical Department Supervisor

J. C. Balaguero, Licensing Engineer *S. Feith, Operations QA Supervisor

Other licensee employees contacted included technicians, operators, mechanics and security force members.

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized on July 2, 1982, with those persons indicated in paragraph 1 above. The inspector maintained frequent unprogrammed discussions and communications with the plant manager during the inspection report period. The licensee did not take exception to the findings discussed in this report.

- 3. Licensee Action on Previous Inspection Findings
 - a. (Closed) Violation (50-250, 251/82-21-01) Failure to follow procedure 0. P. 2500.1, "Heat Tracing System -Normal Operation": The inspector reviewed the licensee's corrective action and confirmed its implementation.
 - b. (Closed) Violation (50-251/81-28-01) Failure to implement material accountability and housekeeping during refueling with the reactor cavity open. The inspector reviewed the licensee's corrective action and had no further questions.

4. Unresolved Items

Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve noncompliance or deviations. New unresolved items identified during this inspection are discussed in paragraph 5.

5. Licensee Event Report (LER) Followup

The following LER's were reviewed and closed. The inspector verified that reporting requirements had been met, causes had been identified, corrective actions appeared appropriate, generic applicablility had been considered, and the LER forms were complete. Additionally, for those reports identified by asterisk, a more detailed review was performed to verify that the licensee had reviewed the event, corrective action had been taken, no unreviewed safety questions were involved, and violations of regulations or technical specification conditions had been identified.

- a. 250-81-08, Charging System Drain Line The inspector reviewed the plant work order (PWO) utilized for the repair (PWO #1619). A plant charge/modification, PC/M 81-40 and 41 for Units 3 and 4 respectively, which will change the design of the vent and drain assemblies was transferred to the Maintenance Department for implementation on 12/28/81. The new design is intended to reduce failure of the high pressure system vent and drain assemblies due to vibration.
- b. 250-81-12, Westinghouse NBFD relays PC/M 81-142 was issued for implementation by the Instrumentation and Control Department on 11/12/81. This PC/M calls for replacement of coils on all NBFD relays used in reactor trip and safeguards applications. At the conclusion of the inspection report period, all safeguards coils (normally de-energized) on Units 3 and 4 had been replaced. The licensee intends to replace the reactor trip coils during the next refueling outage on Unit 3 and during the steam generator repair outage on Unit 4.
- c. 250-81-17, Safety Injection Surveillance Test
- d. 250-82-02, West Fire Pump During review of this LER the inspector was unable to obtain the necessary documentation relating to testing of the pump prior to releasing the clearance associated with the calibration of pressure switch PS-2334. This calibration was performed under PW0-8332, which was completed on February 18, 1982, at which time equipment clearance order 2-256 was released. The inspector requested the post maintenance operability testing documentation from the licensee. At the conclusion of the inspection report period, this documentation was unavailable. This item will be carried as unresolved item 50-250/82-24-03.
- e. 250-81-11, Fire Stop Inoperable 250-81-14, Fire Stop Inoperable 250-82-01, Fire Stop Inoperable

The inspector reviewed the cause description and corrective actions associated with these three LERs. The wording of item 27 (cause description and corrective actions) of NRC form 366 for LER 81-11 and 81-14 was noted to be identical. The basic similarity of these three LER's is indicative of ineffective corrective action.

Paragraph 5.3.1.d of Quality Procedure (Q. P.) 16.1, "Corrective Action", of the operations Quality Assurance Manual states, in part, the following:

For significant conditions adverse to quality, which are reportable, the cause of the condition shall be determined and documented and corrective action shall be taken to prevent recurrence.

In as much as recurrence has not been prevented, the corrective action was inadequate and therefore is contrary to the requirements of Q. P. 16.1. This is a violation (50-250, 251/82-24-01).

6. Plant Operations

The inspector kept informed on a daily basis of the overall plant status and any significant safety matters related to plant operations. Discussions were held with plant management and various members of the operations staff on a regular basis. Selected portions of daily operating logs and operating data sheets were reviewed during the report period. The inspector conducted various plant tours and made frequent visits to the control room. Observations included witnessing work activities in progress, status of operating and standby safety systems, confirming valve positions, instrument readings and recordings, annunciator alarms, housekeeping, radiation area controls, and vital area controls. Informal discussions were held with operators and other personnel on work activities in progress and the status of safety-related equipment or systems.

A considerable amount of time was devoted to witnessing and following corrective maintenance on the 4B High Head Safety Injection (HHSI) pump. The inspection covered a period of 12 days from 6-14-82 to 6-25-82. A chronological account of the maintenance is as follows:

- 5/14/82 From 1430 to 1600, the 4B HHSI pump was tested for vibration only. The Pump was fully instrumented by BENTLY-NEVADA Corporation with vibration accelerometers, associated oscilloscopes and recorders. The test was conducted in accordance with OP 4104.1 (HIGH HEAD SAFETY INJECTION SYSTEM-PERIODIC TEST 4/1/82)
- 6/15/82 Analysis of data obtained on 6/14/82 led to the decision to replace the rotating element.
- 6/16/82 The plant work order was issued and the equipment clearance order was processed.

- 6/18/82 Pump disassembly was completed and an FPL rebuilt element was installed.
- 6/20/82 Attempts to hand turn the pump indicated binding. Disassembly of the pump was commenced in order to install another rebuilt element.
- After encountering much difficulty in obtaining proper bearing alignment, the pump assembly was completed and hand turned without evidence of binding or interference. The test was then started and ran in a manner identical to that used on 6/14/82. The pump initially ran smoothly, but after 28% minutes of running the vibration level began to increase. Close inspection of the pump revealed, that the inboard seal was leaking. The test was terminated at that point.
- 6/25/82 Replacement of inboard seal and testing was completed satisfactorily. The pump was ran for 80 minutes during this test.

The pump was the declared operable at 1540 hours on June 25, 1982. During the maintenance, the inspector noted the failure to fully adhere to the requirements of the radiation work permit (RWP) in effect for general area entry and observation. RWP - 197 specified use of shoe covers, gloves and a lab coat.

The inspector noticed four individuals who had entered the maintenance area without putting on a lab coat. Once this was brought to the attention of the health physics supervisor, the condition was corrected. The failure to adhere to the requirements of the RWP are contrary to the requirements of two O.P.'s: Step 4.4 of O.P. 11550.1, Radiation Work Permit, states that "All protective clothing and contamination control requirements shall be met prior to beginning work under an RWP." Step 8.3.1 of O. P. 11550.2, Radiation Rule of Practice, states that "All persons working with radioactive material where contamination of the person is possible shall wear protective clothing appropriate to the work involved, as stated in the Radiation Work Permit. The color of this clothing is normally yellow." The failure to follow procedure is a violation (50-250 and 251/ 82-24-02.)

In order to allay concerns expressed by the inspector in reference to the disportioning of contaminated equipment clearance tags following completion of maintenance activities, the licensee committed to the following:

- a. To incorporate, in O.P. 11550.2, Radiation Rules of Practice, the requirement that Health Physics be notified in all instances where contamination is detected on material (e.g. clearance tags) originating from areas thought to be clean. The licensee committed to implementing this procedural change by August 2, 1982.
- b. To determine, by August 2, 1982, the impact of discarding contaminated equipment clearance tags on the post maintenance system operability verification function.

Additionally, the licensee committed to incorporating the "Annunciator Control Policy" promulgated in a May 28, 1982 inter-office correspondence signed by the plant manager into formal plant procedures. The committeent date for this action was established as August 2, 1982.

The above three committments will be tracked as inspector followup item 50-250,251/82-24-04.

7. Surveillance Test Observation

On June 16, 1982, the inspector witnessed the performance of O.P. 14004.2, Reactor Coolant Flow Protection Channels Periodic Test, on Unit 3 and O.P. 3104.1, Component Cooling Water System Periodic Test, on Unit 4. The inspector verified the following aspects of these surveillance tests: the procedures conformed to technical specification requirements; proper licensee review; test instrumentation was calibrated; removal of the system from service; conduct of the surveillance test; restoration of the system to service; review of the test data for accuracy and completeness; confirmation that surveillance test documentation was reviewed and test discrepancies were rectified; test results satisfied technical specification requirements; testing was done by qualified personnel; and the surveillance schedule for this test was met.

On June 23, 1982, the inspector observed portions of the performance of O.P. 7304.1, Auxiliary Feedwater System - Peridic Test. The inspector ascertained that the following objectives were being met: testing was scheduled in accordance with technical specification requirements, procedures were being followed, testing was performed by qualified personnel, LCOs were being met, and system restoration was correctly accomplished following testing.

No violations or deviations were identified within the areas inspected.

8. Plant Tours

Various plant tours were conducted by the inspectors. Attention was focused on the operability of safety-related equipment in the following areas: cable spreading room; inverter and battery room; motor generator set and battery rooms; rod control equipment rooms; switchgear rooms; diesel generators rooms and day tank rooms; and auxiliary building.

No violations were identified within the areas inspected.