

MEMORANDUM
ATLANTA, GEORGIA

84 FEB 23 A 8:40



February 21, 1984
L-84-35

Mr. James P. O'Reilly
Regional Administrator, Region II
U. S. Nuclear Regulatory Commission
101 Marietta Street NW, Suite 2900
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Inspection Report 83-38

Florida Power & Light Company has reviewed the subject inspection report and a response is attached.

There is no proprietary information in the report.

Very truly yours,

A handwritten signature in cursive script, appearing to read "J. Williams, Jr.", is written over the typed name.

J. W. Williams, Jr.
Vice President
Nuclear Energy Department

JWW/PLP/dc

Attachment

cc: Harold F. Reis, Esquire
PNS-LI-84-56

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PDR ADOCK 05000250
Q PDR

ATTACHMENT

**RE: TURKEY POINT UNITS 3 AND 4
DOCKET NOS. 50-250, 50-251
INSPECTION REPORT 83-38**

FINDING:

1. Technical Specification 3.4.2.6 requires that two containment spray pumps be operable during normal power operation.

Contrary to the above, both Unit 4 containment spray pumps were inoperable during power operations for approximately 50 hours commencing from October 2, 1983.

RESPONSE:

1. FPL concurs with the finding
2. The containment spray pumps were inoperable because manual header stop valves 4-891A and 4-891B were inadvertently closed by an operator who had been directed to close the corresponding valves on Unit 3, which was in cold shutdown.
3. Valve 4-891B was immediately opened and locked open when discovered. The monthly safety system flowpath verification was performed and no discrepancies were found. Appropriate disciplinary action was taken against the operator. Valve 4-891A was opened and locked open following completion of the monthly surveillance test of the 4A containment spray pump.
4. In order to prevent recurrence the following actions have been taken.
 - A. Operations management held meetings with all operating shifts to discuss the incident.
 - B. New administrative controls were established for ECCS locked valves so that the key for these valves is under direct control of the Plant Supervisor.
 - C. New locks were installed on the locked valves so the locks on Unit 3 valves have different keys than locks on Unit 4 valves.
 - D. The locks were color coded so that Unit 3 locks are red, Unit 4 locks are green and common locks are white.
 - E. Signs have been posted on rooms and equipment clearly differentiating Unit 3 from Unit 4.
5. Full compliance was achieved prior to October 17, 1983.

FINDING:

2. Technical Specification 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 Sections 5.1 and 4.3 of ANSI N18.7-1972 and Appendix "A" of USNRC Regulatory Guide 1.33.

The licensee failed to comply with Technical Specification 6.8.1 on several occasions. Separate occasions are discussed in a through e, listed below:

- a. Licensee Administrative Procedure (AP) 0103.2, dated September 22, 1983, requires operators to correct or document problems with annunciators and indicators.

Contrary to the above, the following annunciator and indicator problems existed without corrective or documentary actions being taken until questioned by the resident inspector on October 18 (Items 1 and 2) and October 11 (Item 3).

- (1) A failed pen trace on channel 2 of the Unit 4 power range recorder (No. 426) such that channel 2 indicated approximately 60% power while the reactor was operating at 100% power.
- (2) A failed startup rate meter on the Unit 3 source range nuclear instrument (N-32) such that the control room meter indicated a constant positive startup rate of 0.75 decades per minute.
- (3) Removal of the Unit 4 480Vac "E" transformer low ground and high temperature annunciator nameplate such that the annunciator could not be identified by visual observation.

RESPONSE:

1. FPL concurs with the finding.
2. The Control Room personnel were monitoring equipment and taking corrective action, but were doing so with priorities set by each individual instead of taking action on all indication problems with the same high degree of importance.
3. The problems listed have been repaired.
4. Operations personnel have been instructed in written statements and in shift meetings with the Operations Supervisor during November and December, 1983, to monitor all instrumentation, and to know its status, and to submit work orders on all malfunctioning equipment. In addition, the importance of taking and documenting corrective action is being emphasized by operations management by discussing instrumentation status with individual operators on shift.
5. Full compliance was achieved on January 20, 1984.

FINDING:

2. b. Steps 4.3 and 4.5 of O.P. 11550.1, Radiation Work Permit, require that personnel who enter an area where an RWP is required be aware of radiological conditions, clothing requirements and special instructions listed on the RWP. In addition, all contamination control requirements shall be met prior to beginning work under an RWP.

Contrary to the above, two individuals (TLDs 504 and 11680 on RWP 161) failed to sign out with Health Physics, on Form HP-2, after exiting a locked high radiation area on October 13, 1983. In addition, one individual (TLD 13504) did not meet the clothing requirements of RWP-55 on October 24, 1983.

RESPONSE:

1. FPL concurs with the findings.
2. The reason for the finding was that the two electricians forgot to sign out on the HP-2 form upon exiting the Unit 4 B RHR room. The one individual that did not meet the posted clothing requirements was in a hurry due to a problem with some fuel-sipping equipment.
3. Immediate corrective action taken was to restrict the two electricians from the Radiation Controlled Area. The Health Physics Shift Supervisor and the Reactor Engineering Supervisor took corrective action with the electricians and the fuel sipper, respectively, to ensure the individuals understood their responsibilities toward posted RWP requirements. HP-2 forms were also reviewed and no similar incidents were discovered.
4. To avoid future problems, Operating Procedure 11550.101 has been revised to formulate effective incident reporting techniques.
5. Full compliance was achieved on January 12, 1984.

FINDING:

2. c. Licensee Operating Procedure (OP) 13514.2, dated June 25, 1981, requires technicians to document both the failure of the local leak rate test (if applicable) and any problems encountered while performing the test.

Contrary to the above, on October 16, 1983, a technician failed to indicate that the local leak rate test of the emergency air lock was unsuccessful as required by OP 13514.2, step 8.3.5. Additionally, he failed to document problems associated in completing the test as required by OP 13514.2, step 9.2.

RESPONSE:

1. FPL concurs with the finding.
2. The reason for the finding was that the technician was confused by the wording of the procedure step requiring retest of the seals and by the fact that the emergency air lock wasn't required to be operable (due to plant conditions) prior to the test.
- 3 and 4 Corrective action taken was to change Operating Procedure 13514.2 to clarify the intended requirement of the test. This subject was also brought to the attention of all personnel in the systems performance group to assure that applicable comments are made in the remarks section of procedures. In addition, the policy on handling discrepancies has been refined and clarified to specifically address the need to properly document discrepancies identified during surveillance testing.
5. Full compliance was achieved on November 17, 1983.

FINDING:

2. d. Step 8.3.4 of administrative procedure, A.P. 103.2, Duties and Responsibilities of Operators on Shift and Maintenance of Operating Logs and Records, requires that the oncoming operator(s) review their stations' Log Book for the previous 24 hours and current Log Sheets, then initial the left hand column next to their shift entry.

Contrary to the above, on October 2, 1983, the oncoming operator did not perform an adequate review of the log sheets and did not indicate with an initial in the log sheet left hand column.

RESPONSE:

1. FPL concurs with the finding.
2. The operator that failed to review and initial the log was called out to work on an emergency basis to fill a position vacancy that occurred during the shift. The operator who was called out completed an evolution that was in-progress when he arrived on station, as directed by control room personnel and the log was not properly reviewed.
3. As corrective action the operator reviewed and initialed the log.
4. To prevent future occurrences of this problem, the Operations Supervisor had a meeting with the operator emphasizing the importance of procedure requirements. The procedure requirements regarding proper review of logs were a topic of discussions during shift meetings. In addition relief checklists have been developed to better aid and direct operators to assure a complete turnover from shift to shift.
5. Full compliance was achieved on December 8, 1983.

FINDING:

2. e. Step 8.16 of O.P. 205.2, Reactor Shutdown - Hot to Cold Shutdown Condition, requires that upon shutting the A and/or B containment spray pump isolation valves 891A and B, the valves be closed, locked and tagged.

Contrary to the above, the operator who mistakenly closed these valves on Unit 4 on October 2, 1983, failed to tag the valves he had closed and by his omission, disabled the independent verification of his actions as was required by the equipment clearance order.

RESPONSE:

1. FPL concurs with the finding.
2. There was a misunderstanding between the plant supervisor and the reactor operator as to verbal instructions concerning placing the residual heat removal system in service. The reactor operator instructed the nuclear operator to proceed with the procedure and stated that the clearance for specific valves would follow later. This was not the intent of the plant supervisor.
3. The importance of complying with each step of a procedure and that the action is not complete until all the requirements of the step are met has been discussed with operating personnel, during shift meetings. Emphasis was placed on clearance and tagging requirements of specific procedure steps. Independent verification was also stressed in a special instruction dated October 13, 1983. A new plant policy has been issued by the plant manager to provide additional direction and emphasis on independent verification.
4. Full compliance was achieved on December 8, 1983.

FINDING:

3. Technical Specification 6.8.3 requires that changes to the procedures governed by TS 6.8.1, if made, shall be approved by two members of the plant management staff, at least one of whom holds a Senior Operating License on the unit affected.

Contrary to the above, on or before October 19, 1983, a procedural change was made to Operating Procedure 16200, entitled "Manipulator Crane Operating Instructions" and dated September 29, 1983. The change was not approved by two members of the plant management staff prior to being utilized.

RESPONSE:

1. FPL concurs with the finding.
2. The reason for the finding is that it was not considered that the memo in the Operation's Supervisors information notebook constituted a change to the procedure.
3. As immediate corrective action, the change to Operating Procedure 16200 was processed as an On-The-Spot-Change in compliance with Technical Specification 6.8.3. The change has been permanently incorporated into the procedure.
4. The increased awareness of the Operations Supervisor that short term instructions may constitute procedure changes, combined with the increased emphasis by plant management on procedure adherence, will ensure that direction given for plant evolutions will be performed by approved procedures.
5. Full compliance was achieved prior to October 25, 1983.

FINDING:

4. 10 CFR 50.72 as implemented by item 3 of Appendix A to Administrative Procedure (AP) 103.12 Notification of Significant Events to NRC, requires reporting to the NRC Operations Center any event that results in the unit not being in a controlled or expected condition while operating or shutdown.

Contrary to the above on two occasions (October 7, 1983 - Uncontrolled RCS Heatup and October 2, 1983 - Containment Spray Isolation) the NRC Operations Center was not notified.

RESPONSE:

1. FPL concurs with the finding.
2. The failures to report to the NRC Operations Center via the ENS telephone were caused by the operator's failure to follow Administrative Procedure 0103.12.
- 3 and 4 A written statement was issued to the responsible personnel on October 12, 1983 and during shift meetings held November 9 through December 8, 1983. Instructions in the statement were given to the Plant Supervisors - Nuclear and all shifts that significant event reporting requirements must be complied with whether or not the NRC was otherwise contacted. The instructions emphasized that operating personnel must question and verify if an incident is reportable. Several additional mechanisms have been put in place in order to provide additional assurance that plant management is informed of significant events.
5. Full compliance was achieved on December 8, 1983.