



APRIL 20 1988

L-88-186

88 APR 25 4:10:02

Dr. J. Nelson Grace
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta Street, N. W., Suite 2900
Atlanta, Georgia 30323

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Management-on-Shift Weekly Report

Dear Dr. Grace:

Pursuant to the Nuclear Regulatory Commission Order dated October 19, 1987, the attached summary of Management-on-Shift (MOS) reports is submitted. The PS-N MOS Reports are also being submitted.

Should there be any questions on this information, please contact us.

Very truly yours,

W. F. Conway

W. F. Conway
Acting Group Vice President
Nuclear Energy Department

WFC/SDF/gp
Attachment

cc: J. Lieberman, Director, Office of Enforcement, USNRC
Dr. G. E. Edison, Project Manager, NRR, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant
R. E. Tallon, President, FPL

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R PDR

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMMARY REPORT

WEEK STARTING: 04/11/88

PAGE 1 OF 2

Five MOS Observers were on shift; Charles Stack, St. Lucie Nuclear Plant Quality Assurance Department (04/11-17/88, days), Richard Coulthard, Westinghouse Electric Corporation (04/17/88, day), Dennis Borgmann, St. Lucie Nuclear Plant Non-Licensed Operator Training Supervisor (04/11-18/88, evenings), Steven T. Hale, Turkey Point Nuclear Site Project Engineering Supervisor, (04/11-15/88, evenings), and Vito A. Kaminskas, Turkey Point Nuclear Plant Reactor Engineering Supervisor (04/15-18/88, evenings).

Both Units 3 and 4 operated at 100% power throughout the entire reporting period.

No immediate safety problems or questionable work practices were reported by the regular MOS Observers during the reporting period.

During the reporting period, the MOS Observers noted twenty-five recommendations or areas for improvement. These comments and suggestions included:

Four comments on improvements in procedure-related items associated with Turbine Operator logs, Technical Specification (TS) Implementation Procedure requirements for setpoint reduction with one Power Range Channel out-of-service, review of procedures by operators before final implementation and Component Cooling Water System alignment during an In-Service Test.

Six comments concerning equipment status such as maintenance on Diesel Generator temperature indicators, method of filling the Primary Lab Water Tank and priorities for cleaning intake Cooling Water Strainers.

Five comments concerning methods to improve work flow such as insuring PWO's have complete information when inputted into the computer, providing a schedule for TS related work and altering the schedule for the conduct of surveillances.

Three comments associated with industrial safety and housekeeping items such as missing insulation on the Feedwater System and cleanliness in the condenser pit.

ATTACHMENT: MOS DAILY REPORTS

MANAGEMENT ON SHIFT (MOS)

WEEKLY SUMMARY REPORT

WEEK STARTING: 04/11/88

PAGE 2 OF 2

Seven miscellaneous comments were made on items such as improved training for the Technical Specification Implementation Procedure, information tags for the Control Board and correct operator actions to maintain and monitor Reactor power with the computer for calculating the calorimetric out-of-service.

The PSN's identified five questionable work practices such as the length of time to complete PWOs on the B Diesel Generator temperature indicators, wrong component identified on a PWO, ladder and scaffold erection practices and compliance with procedural sign off requirements.

Additionally, the PSN's identified twelve areas for improvement. These suggestions included:

Two comments on interpretation of the Technical Specification Implementation Procedure concerning a Power Range detector out-of-service and requirements for the Diesel Generator availability test prior to taking a Startup Transformer out-of-service.

Five comments associated with equipment and Plant Work Orders such as spurious alarms on the Fire Detection panel, availability of parts and tags prior to removing equipment to conduct PWOs and operator participation in system-of-the-week reviews to return automatic systems to service.

Five comments associated with miscellaneous items such as updating operating parameters on log sheets, removing an Intake Cooling Water Pump and Strainer in separate trains at the same time and obtaining advance notice from the System Dispatcher prior to removing a Startup Transformer from service.

ATTACHMENT: MOS DAILY REPORTS

To: Operations Superintendent - Nuclear

Date: 04/11/88

From: Charlie Stack
(MOS Observer)Shift: Day
 Night**A. Plant evolutions observed**

- Mid shift
 - Unit 3, 100% power, normal operation
 - Unit 4, 100% power, normal operation
 - Unit 4, loss of mid Oil-Controlled Breaker and recovery
 - End of shift briefing
- Day Shift
 - Shift turnover, mid to day
 - Pre shift briefing
 - Unit 3, 100% power, Intermediate Range Nuclear Instrumentation Analog Instrumentation Test, Rod Position Indication (RPI) alarm loop periodic test, RPI periodic test of power supply, Chemistry test of feed flow elements
 - End of shift briefing
- Peak shift
 - Shift turnover, day to peak
 - Shift briefing

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

While I & C and Chemistry Departments were performing a calibration check of the Unit 4 feedwater flow elements, the calorimetric calculation of thermal power performed by the Digital Data Processing System (DDPS) was "off target". This is utilized by PTN to serve as the legal record of power output for Unit 3 and 4. During this evolution the RCO did not dilute to maintain reactor power, but rather let power slowly decay. During this time Nuclear Instrumentation power ranged from 101 to 99 percent power depending on the channel observed. When queried about whether there was policy or procedural guidance in this area, RCO responses indicated that there is neither policy or procedural guidance on what to use as an indication for core output when the DDPS calorimetric calculation is out-of-service for a short period. Further, some RCO's suggested that they would dilute to maintain reactor power at some level while other RCO's would do nothing or even borate.

Plant management should provide some form of continuity via policy or procedure to address the aspects mentioned above.

E. Professionalism, Summary of Shift, Comments

1. Mid shift did very well in responding to a trip of the mid Oil-Controlled Breaker on Unit 4. Operations personnel did well to coordinate with the dispatcher to get the breaker checked and reclosed.
2. Day shift personnel did a very good job in the areas of procedural compliance and coordination of unit operation in light of an, at times, staggering work load. Much was accomplished in a timely, efficient manner. However, the Control Room crew was loaded down to near capacity with work to accomplish.
3. Observations of the three shifts in the Control Room demonstrated some commonalities between the different Control Room crews. On each shift, the maintenance to be performed is scheduled ahead of the shift via a scheduling process. During the course of a shift, various additional maintenance items emerge as "necessary to be performed". When this occurs, and requests by the PSN and/or APSN are made to Maintenance to work these items, it was observed that, in some instances, Maintenance personnel want only to perform the scheduled work. The PSN and/or APSN were observed to "not pursue" this in a vigorous enough manner. In effect, this gives control of the plant to the Maintenance Department.

Operations Department is tasked with the personnel licensed to operate the plant (RCO and SRO). The PSN and/or APSN must take and maintain direct control of the shift. This includes getting Maintenance to perform the work Operations needs done to run the plant in a safe manner.

Discussion with various operators showed that they do not feel they have Management's direct support to take positive and assertive control of the shift operation relative to maintenance activities.

4. Peak shift briefing was excellent. It was a very good example of the teamwork that PTN staff is capable of performing. The safe, stable operation of the plant through teamwork was the idea that was impressed upon each member of the crew.

F. Recommendations

Management must make known to the department personnel in the field it's goal of putting Operations in the driver's seat at PTN. This must be done while stressing that teamwork is the only way that PTN can operate correctly and effectively.

Management must also provide means to accomplish this teamwork approach which the men in the field can grasp and accomplish.

Completed By: Charlie Stack Date: 04/11/88
MOS Observer

Reviewed By: [Signature] Date: 4/12/88
Operations Superintendent - Nuclear

Management Review By: CB 14/12/88 1 [Signature] 1 4/12/88
PM-N Date SVP Date VP Date
04/11/88

To: Operations Superintendent - Nuclear

Date: 04/11-12/88

From: D. Borgmann
(MOS Observer)Shift: Day
 Night

A. Plant evolutions observed

- 100% Steady state operations - both units
 - 1705 Nuclear Instruction Channel failed on Unit 3, ONOP procedure carried out
 - 2100 Troubleshooting commenced
 - 2230 End of shift meeting
 - 2310 Pre shift brief

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None noted

E. Professionalism, Summary of Shift, Comments

- 1. Peak shift was very busy. The PSN and APSN maintained control and resolved an Interim Tech. Spec. concern with failed Nuclear Instrumentation Channel N-44.
- 2. Peak shift I & C supervision seemed very knowledgeable on troubleshooting N-44. He stayed in the Control Room until specialists could go no further.
- 3. Mid shift NWE when making a tour noticed that the SOLA Transformer supplying N-44 was cold. This prompted Electrical Maintenance and I & C to look at the transformer as a possible cause for the loss of Channel N-44. Electrical found a loose lug on the transformer.

F. Recommendations

None

Completed By: D. Borgmann
MOS Observer

Date: 04/11-12/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/12/88

Management Review By: [Signature] 11/15/88
PM-N Date SVP Date

[Signature] 14/12/88
VP Date
04/11-12/88

To: Operations Superintendent - Nuclear

Date: 04/11-12/88

From: S. T. Hale
(MOS Observer)Shift: Day
 Night

A. Plant evolutions observed

- Unit 3, 100% power operation
- Unit 4, 100% power operation

B. Immediate safety problem

None

C. Questionable work practices

None

D. Area(s) for improvement

1. A great deal of confusion arose over the Interim Tech. Spec's related to loss of a Power Range Detector on Unit 3. Although appropriate actions were taken, the Interim Tech. Spec's should be clarified in this area.
2. I & C Maintenance Specialist was observed standing on a rolling high chair to work on Radiation Monitoring Channel R-11 on Unit 4.

E. Professionalism, Summary of Shift, Comments

The Nuclear Watch Engineer did a excellent job of troubleshooting the problem with the Power Range Detector. He was able to focus attention on the root cause of the problem by looking at available information and inspections.

F. Recommendations

See D.1 and D.2.

Completed By: S. T. Hale
MOS Observer

Date: 04/11-12/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/12/88

Management Review By: OPS 14/12/88
PM/N Date SVP Date

[Signature] 14/12/88
VP Date

Date Started 04/11/88

PSN MOS

Date Finished 04/12/88

Initiating PSN Jones PSN Guyer Completed PSN Harpel

Initiating APSN Haley APSN Vetromile Completed APSN Murphy

A. Questionable Work Practice/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Day shift - None

Peakshift - Nuclear Instrumentation Channel N-44 failed and was removed from service. Upon consulting O-ADM-021, it was noted that Table 3.3-1, Action Statement 2C states if Quadrant Power Tilt Ratio could not be verified by a flux map, Reactor power would have to be reduced to 75% and overpower trip setpoints reduced to 85%. This would not be possible since one channel is already out-of-service and to reset and establish the other overpower trip setpoint would require taking the other channels out-of-service one at a time. However, this condition would have two channels out-of-service which would either cause a Reactor trip or be less than the required channels operable.

C. Good Practices/Professionalism Observed

Day - None

Peakshift - Good coordination and communications between Operations Supervision, Licensing, Reactor Engineering and PUP in resolving and interpreting O-ADM-021, Table 3.3-1 and the Action Statements associated with it.

Reviewed By [Signature] Date 4/2/88 Actions Completed _____ Date _____

To: Operations Superintendent - Nuclear

Date: 04/12/88

From: Charlie Stack
(MOS Observer)Shift: Day
 Night**A. Plant evolutions observed**

- Mid shift
 - Unit 3, 100% power, normal operation
- - Unit 4, 100% power, normal operation
 - End of shift briefing
- Day shift
 - Shift turnover, mid to day
 - Pre-shift briefing
 - Unit 3, 100% power, normal operation
 - Unit 4, 100% power, normal operation, Reactor Protection System (RPS) functional testing
 - End of shift
- Peak shift
 - Shift turnover, day to peak
 - Shift briefing

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

1. Timely job planning/execution particularly where safety-related system operability is concerned. On 4/9/88 a PWO was issued for maintenance to clean 3A Intake Cooling Water (ICW) strainer due to a high differential pressure (DP). As of 1 PM on 4/12/88, the strainer had not been cleaned. The differential pressure was now greater than 3 psid. Backwashing was now impossible because the vendor informed PTN that the strainer cannot structurally withstand backwashing at greater than 2 psid. This practice is entirely unacceptable. The criteria for initiation of backwash of these strainers is at 1.0 to 1.2 psid. However, when the DP goes high enough that backwashing is impossible, immediate attention must be given to cleaning the strainer because as DP increases, that ICW header's operability becomes questionable. At 1 PM the DP on 3B ICW strainer was 1.5 psid.

E. Professionalism, Summary of Shift, Comments

- 1. Personnel on Units 3 and 4 conducted themselves in a very positive manner today. Very good teamwork was evident during performance of Unit 4 RPS Functional Testing.

F. Recommendations

None

Completed By: Charlie Stack
MOS Observer

Date: 04/12/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/13/88

Management Review By:

<u>[Signature]</u>	<u>11/7/88</u>	<u>[Signature]</u>	<u>14/13/88</u>	<u>[Signature]</u>	<u>14/13/88</u>
PM-N	Date	SVP	Date	VP	Date

To: Operations Superintendent - Nuclear

Date: 04/12-13/88

From: D. Borgmann
(MOS Observer)

Shift: Day
 Night

A. Plant evolutions observed

- o 2000, Maintenance on Nuclear Instrumentation Channel N-44
- o 2145, Observed performance of 3-OSP-059.4, Power Range Nuclear Instrumentation Analog Operational Test
- o 2330, Pre shift brief

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None

E. Professionalism, Summary of Shift, Comments

None

F. Recommendations

None

Completed By: D. Borgmann
MOS Observer

Date: 04/12-13/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/13/88

Management Review By: C/13 14/13/88 [Signature] 14/13/88 [Signature] 14/13/88
 PM-N Date SVP Date VP Date
 04/12-13/88

To: Operations Superintendent - Nuclear

Date: 04/12-13/88

From: S. T. Hale
(MOS Observer)Shift: Day
 Night

A. Plant evolutions observed

- ° Unit 3, Operation at 100% power
- ° Unit 4, Operation at 100% power

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

1. There was an inordinate amount of dead time in the repair of N-44 Power Range Channel. Actual troubleshooting took between $\frac{1}{2}$ to 1 hour, engineering duration (preparation of DEEP package) took about 3 hours and actual repair and clearance took an additional 3 hours. The detector was out-of-service for about 25 hours; equating to approximately 18 hours of dead time. Considering the fact that a spurious signal on any one of the other detectors would have tripped the unit, there needs to be an expedited method for repairs that threaten plant availability.
2. The 4A Feedpump discharge check valve has no insulation on the bonnet for no apparent reason. Considering the temperature of the system, this poses a personnel safety hazard.

E. Professionalism, Summary of Shift, Comments

Smooth shifts with good communications and transfer of information at turnover.

F. Recommendations

1. Replace 4A Feedwater Pump discharge check valve bonnet insulation.
2. There should be some means to activate all concerned departments for Al priority PWO's.

Completed By: S. T. Hale
MOS Observer

Date: 04/12-13/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/13/88

Management Review By:

[Signature] 4/13/88 [Signature] 4/13/88
 PM-N Date SVR Date VP Date

Date Started 04/12/88

PSN MOS

Date Finished 04/13/88

Initiating PSN Jones PSN Guyer Completed PSN Anderson

Initiating APSN _____ APSN Vetromile Completed APSN _____

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

Day shift - The Turbine Operator expressed his frustration in getting operating parameters in Log Sheets changed to more realistic values. PUP's representative at the morning meeting explained that 21 changes had been presented to our System Engineers back in November of 1987 and as of yet, they have not received justification to change any of these parameters.

1. I recommend that our System Engineers give Operations and PUP a report on what progress is being made on these requested parameter changes.

C. Good Practices/Professionalism Observed

None

Reviewed By [Signature] Date 4/13/88 Actions Completed _____ Date _____

Continuation Page

Page 2 of DDate: April 13, 1988Shift: Day
 Night

PTN Training department was contacted on 4/12/88 to inquire about the need for training licensed operators on the Interim Tech. Specs. The reasons given for not providing this training were:

1. The nature of the disclaimers in section 3.1 of O-ADM-021.
2. The Interim Tech. Specs are nearly always waived.
3. Why train on an item for which there is no consistent policy?
4. Why require the licensed operators to learn an additional set of Tech. Specs?

Also discussed was the understanding by PTN Training Department that if training was provided to licensed operators, then they would have to be tested on the information presented and PTN Training Department did not:

1. Want to test the licensed operators on the Interim Tech. Specs.
2. Lose their accreditation if they decided not to test the licensed operators on the Interim Tech. Specs.

INPO Document 88-001, dated 3/88, entitled "Maintaining Accreditation of Training in the Nuclear Industry" states "...Test items.... of objectives...shall be based on trainee performance... in initial and continuing training programs." No mention is made about losing accreditation or the exact nature of test questions required were the operators to be trained on the Interim Tech. Specs. The training could be specifically designed to meet licensed operator's needs and not jeopardize accreditation.

Licensed operators clearly need and want training on the Interim Tech. Specs.; particularly in view of the ramifications of Tech Specs. involving items such as:

1. Emergency Diesel Generators
2. Fire protection
3. Rod Position Indication

Further discussion on this item was conducted with Operations Supervision. In this discussion the following points emerged:

1. There is a consistent policy from PTN Management to licensed operators on the use and interpretation of the Interim Tech. Specs.
2. Waivers are in fact granted on very few occasions
3. Training on the new (Interim) Tech. Specs. format might be desirable and helpful to licensed operators.

Charlie Stack
MOS Observer

Recommend reconsideration by PTN Training Department in the area of providing training to licensed operators on the Interim Tech. Specs. including at least the format. Implementation of the Final Tech. Specs in standardized format might thus be an easier process, once they are approved by the N.R.C.

2. A review was made of the test program for Safety Injection Pumps. In discussions with the Technical Staff Test Group, an item for plant consideration emerged. It seems that calibration of the gauges used during surveillance testing of the SI pumps is accomplished by the I&C Department, but controlled by the Tech. Staff Test Group. Each year the Test Group initiates a PWO to have these groups calibrated. A log of this is kept by the Test Group. If the PWO is not written, the gauges go uncalibrated. However, the prompting of surveillance testing has in the past resulted in getting the gauges calibrated.

Recommend formalizing and thus controlling the system for calibration of these gauges by either:

1. Placing them under the GEM calibration system umbrella.
2. Proceduralizing the Test Group's efforts already in place.

E. Professionalism, Summary of Shift, Comments

1. Turnover to the peak shift was well thought out and well executed.
2. Peak shift's briefing was very good; concise and complete. The PSN and APSN took the driver's seat which was evident right at the start of the shift. All maintenance discipline supervisors were very receptive to this management style. Operations Department was definitely in charge of overall plant operation.

F. Recommendations

None

Completed By: Charlie Stack
MOS Observer

Date: 04/13/88

Reviewed By: *J. W. Pearce*
Operations Superintendent - Nuclear

Date: 4/14/88

Management Review By:

CMS 14/14/88 1 1
PM-N Date SVP Date VP Date

FINAL PAGE

To: Operations Superintendent - Nuclear

Date: 04/13-14/88From: Dennis Borgmann
(MOS Observer)Shift: Day
 Night**A. Plant evolutions observed**

- Plant tour of Secondary areas
- 2100, Diesel Generator Surveillance Test
- 2215, Component Cooling Water leak entry into ONOP
- 2240, End of shift meeting
- 2330, Pre shift briefing
- 0010, Toured RCA observed NO/SNPO

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

1. Calibration of instrumentation used in Diesel Generator (DG) Surveillance testing. Two temperature instruments on the "B" DG have PWO's on them, TI-442B and TI-444B (PWO #'s WA880712026 and 311621). Both are required for the surveillance test. Both PWO's should have been worked within 14 days. One was originated on 2/9/88, the other on 3/11/88. This is a repeat of a previous MOS report.

E. Professionalism, summary of Shift, Comments

- 1. Not having the two temperature indicators on the "B" Diesel Generator (DG) caused, a) Operations to have to make an OTSC, b) rerun the DG surveillance and c) not get #4 Startup Transformer out-of-service until after 1:00 AM (a loss of 8 hours). This is not the first time the surveillance has had to be rerun because of this.
- 2. RCA area is very clean. There are very few areas where a person cannot enter in street clothes.
- 3. CCW leak caused by having 3 CCW pumps running at same time and a relief lifted on the Excess Letdown Heat Exchanger. Technical staff was doing In-Service Testing (IST) of the pump. A change to the procedure is being processed.

F. Recommendations

None

Completed By: Dennis Borgmann
MOS Observer

Date: 04/13-14/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/13/88

Management Review By: [Signature] 14/14/88
PM/N Date SVP Date VP Date

To: Operations Superintendent - Nuclear

Date: 04/13-14/88

From: S. T. Hale
(MOS Observer)Shift: Day
 Night

A. Plant evolutions observed

- Unit 3, 100% power
- Unit 4, 100% power

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

1. The "B" Diesel Generator operability surveillance test had to be performed a second time. Temperature readings for two specific locations were not taken because the installed temperature indicators were out of calibration. Rather than looking for alternate means for temperature readings the readings were waived. Thus, a retest had to be performed. Apparently, this was a repeat occurrence of a recent MOS report.
2. There appears to be the need to better coordinate testing on the Component Cooling Water (CCW) pumps. Apparently, the configuration of 3 CCW Pumps running during testing caused the CCW to the Excess Letdown Heat Exchanger relief valve to lift. Apparently this also was a repeat occurrence. This is a Technical Department Procedure.

E. Professionalism, Summary of Shift, Comments

1. Shift turnover was excellent. Unit status was presented in detail with a good discussion between Operations and Maintenance. The PSN emphasized the need to maintain a professional attitude in implementing procedures.
2. The Auxiliary Building was extremely clean. The efforts of HP to reduce contaminated floor space are obvious.
3. Recovery from the lifting of the CCW to the Excess Letdown Heat Exchanger relief valve was handled very expeditiously and professionally. The SRO analyzed the situation and began taking corrective action within 30 seconds.

F. Recommendations

1. Procedures could be revised to allow and ensure TO's use alternate means for temperature recording for equipment during diesel testing. Also, considering the temperature indicators only need calibration, they should be calibrated.
2. CCW Pumps testing needs to be coordinated to prevent reoccurrence of the problem with the relief valve lifting.

Completed By: S. T. Hale Date: 04/13-14/88
MOS Observer

Reviewed By: [Signature] Date: 4/13/88
Operations Superintendent - Nuclear

Management Review By: [Signature] [Signature] [Signature] [Signature]
PM-N Date SVP Date VP Date

Date Started 04/13/88

PSN MOS

Date Finished 04/13/88

Initiating PSN Jones (Days) PSN _____ Completed PSN _____

Initiating APSN _____ APSN _____ Completed APSN _____

A. Questionable Work Practices/Action Taken/Recommendations

None

B. Area(s) for Improvement/Recommendations/Actions Taken

We had a great plan of the day planned. Then the System Dispatcher requested a clearance on the #4 Start-up Transformer. This requires us to test both Emergency Diesel Generators prior to removing the Start-up Transformer from service. We need them to let us know earlier when jobs like this are needed. Maybe if the System Dispatcher would let the Maintenance Coordinator know of these type clearances 24 hours in advance, we could get it into the plan of the day.

C. Good Practices/Professionalism Observed

None

Reviewed By L. W. Pearce Date 4/13/88 Actions Completed _____ Date _____

Date Started 04/13/88

PSN MOS

Date Finished 04/13/88

Initiating PSN Guyer (Peaks) PSN _____ Completed PSN _____

Initiating APSN _____ APSN _____ Completed APSN _____

A. Questionable Work Practices/Actions Taken/Recommendations

After the performance of the "B" Emergency Diesel Generator Operability Test, it was discovered that the Radiator inlet temp., TI-442B and the Oiler Cooler outlet temp, TI-444B, readings had not been taken. Although PWOs had been written, the readings are still required for operability verifications. Due to this, the test had to be run again, using a contact Pyrometer. The test was performed satisfactorily. More emphasis and awareness needs to be devoted to PWO's of this nature.

B. Areas for Improvement/Recommendations/Actions Taken

During the Technical Department testing of the Component Cooling Water (CCW) Pumps, the Excess Letdown Heat Exchanger safety valve lifted causing Surge Tank level to decrease and the Containment Sump level to increase. With quick operator recognition and actions using ONOP-030 "Loss of Component Cooling Water", the source of the leak was diagnosed. The Nuclear Operator was informed. The CCW valves to the Excess Letdown Heat Exchanger were closed and the leak was stopped.

Recommendation: Technical Department should evaluate the method used to perform this test.

C. Good Practices/Professionalism Observed

Timely use of ONOPs and operator awareness avoided a potential hazardous Plant condition.

Reviewed By R. W. Pearce Date 4/13/88 Actions Completed _____ Date _____

Date Started 04/13/88

PSN MOS

Date Finished 04/14/88

Initiating PSN Anderson (Mids) PSN _____ Completed PSN _____

Initiating APSN _____ APSN _____ Completed APSN _____

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

The fire alarm panel is constantly alarming with trouble alarms. PWOs are written constantly on the spurious alarms and then disappear with the same trouble still happening. This is an every day, every shift problem and has been going on for years.

Recommend: Since our own departments have not been able to solve this problem, we should call in a vendor representative and take their recommendations and fix this problem once and for all. These repeated alarms keep occurring to such a great extent that apathy exists towards the alarms. They mean nothing when they come in.

C. Good Practices/Professionalism Observed

The RCO trainees on shift have been doing a very professional job of helping out in the Control Room. Under the supervision of the RCO's on shift, the trainees have performed log readings, evolutions and expressed a very professional concern for plant equipment status including submitting many PWOs. They have followed the progress of jobs being done and give good feed back to everyone in the Control Room. I have also heard very good discussions related to learning their future jobs as licensed operators.

Reviewed By L. W. Pearce Date 4/13/88 Actions Completed _____ Date _____

W 1/7

To: Operations Superintendent - Nuclear

Date: 04/14-15/88

From: Dennis H. Borgmann
(MOS Observer)

Shift: Day
 Night

A. Plant evolutions observed

- o 2230, End of shift meeting
- o 2330, Pre shift meeting
- o 0130, Main Transformer periodic test
- o 0330, Main Transformer periodic test
- o 0410, Maintenance on Feedwater Control Valve

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None

E. Professionalism, Summary of Shift, Comments

1. I&C was scheduled to perform maintenance on a Unit 3 Feedwater Control Valve. It was scheduled on the Plan-of-the-Day and the package was ready. When the I&C person brought it to the Control Room, he had to initiate a Temporary Status Alteration (TSA) and get parts. Both things could have been started earlier by GEMS or Planning. From discussions with Control Room personnel, this is not the first time this kind of thing has happened. Work had not started at 4 AM.

F. Recommendations

See PSN-Anderson MOS report of 4/15/88.

Completed By: D. H. Borgmann
MOS Observer

Date: 04/14-15/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/15/88

Management Review By:

<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
PM/N	Date	SVP	Date
			<u>4/15/88</u>
			VP
			Date
			<u>04/14-15/88</u>

To: Operations Superintendent - Nuclear

Date: 04/14-15/88

From: S. T. Hale
(MOS Observer)Shift: Day
 Night

- A. Plant evolutions observed
- ° Unit 3, operation at 100% power
 - ° Unit 4, operation at 100% power

B. Immediate safety problems

None

C. Quality work practices

None

D. Area(s) for improvement

The Feedwater Regulation Valve to the 3C Steam Generator needed a pressure gauge replaced on the regulator feeding the positioner. In order to perform the replacement, the regulator valve had to be blocked in position with regulation performed manually using the bypass valve. Operators proceeded to align the system for the prescribed maintenance, but maintenance could not begin because 1) they needed a Temporary Status Alteration (TSA) and 2) they needed a pressure gauge from Stores. This caused undue delays in performing the job.

E. Professionalism, Summary of Shift, Comments

1. During the mid shift loud banging noises were heard coming from the extraction steam line feeding the 4A and 4B feedwater heaters. The APSN did an excellent job of analyzing the situation and taking appropriate actions to eliminate the noise.
2. This was my last night on shift, and my overall impressions of the operations staff is very good. All shifts observed demonstrated a high level of professionalism, and the few minor transients which did occur were handled in an accurate and expeditious manner.

F. Recommendations

Planning needs to be investigated to ensure all parts are in hand and all required paper work is completed prior to taking components out-of-service or placing them in an abnormal configuration.

Completed By: S. T. Hale
MOS Observer

Date: 04/14-15/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/15/88

Management
Review By:

[Signature] 14/15/88 [Signature] 14/15/88 [Signature] 4/15/88
 PM;N Date SVP Date VB Date
 04/14-15/88

To: Operations Superintendent - Nuclear

Date: 04/14/88

From: Charlie Stack
(MOS Observer)Shift: Day
 Night**A. Plant evolutions observed**

- Mid shift
 - Unit 3, 100% power, normal operation
 - Unit 4, 100% power, normal operation
 - End of shift briefing
- Day Shift
 - Unit 3, 100% power, normal operation, Moisture Separator Reheater (MSR) test underway
 - Unit 4, 100% power, normal operation
 - Secondary plant walkdown
 - End of shift briefing

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

1. In general, the secondary plant is quite clean. However a tour of Unit 4 condensate/circulating water pit-east side revealed that this area is in need of attention. There is much trash and stray work materials in the area. Recommend some general housekeeping be conducted in the area.
2. A review was conducted of the planning, scheduling and performance of Tech. Spec. Surveillance testing. The review included a look at O-OSP-200.1. With the present scheduling system there is a tendency for surveillances to become bottlenecked resulting in being required to do many procedures in a very short time span.

Recommendations:

- a. Consider a human factor methodology for O-OSP-200.1 which would encompass a three-tiered hierarchy by unit, train and component. This would allow PTN to gain better control over scheduling.
- b. Combine performance tests, i.e., pumps, valves, etc. This gives PTN greater control over the surveillance program configuration.
- c. Control all tests out of Control Room. Make it standard practice to review tests with RCO's, ASPN's and PSN's. This may help provide continuity of plant operation, thereby decreasing the chances for a reactor trip during this test.

Using a unit-based, three-tiered format would reduce O-OSP-200.1 to 75% of its present size. This scheme can even be used in conjunction with other units.

- d. Instead of waiting for the computerized system to assist in Tech. Specs. surveillance scheduling, consider that on May 1, 1988 PTN begin making the date required for surveillances based on the periodicity specified in Tech. Specs. without adding in the 25% margin. Based upon discussions with the Maintenance Superintendent, the Maintenance Department could accomodate these changes by May 1, 1988 with no problems.
- e. Use a minus 10% variance in the scheduling date for surveillances, it has been demonstrated at utilities with many nuclear units (i.e., FPL) that this will accomodate the load dispatcher's needs on a per annum scheduling basis.

3. Utilize an information tag or some type of formalized reminder tag when such a reminder needs to be attached to the control board. On 4/13/88 an RCO forgot that a preventative maintenance test was being done in the boric acid heat tracing system on Unit 4. He borated to the RCS and the test had to be updated on 4/14/88. This time the RCO used a sheet of paper taped to the control board saying that a heat tracing Preventative Maintenance Test was in progress. While the note served a function in this case, there are logical extensions to this kind of practice, thus making a formalized method of putting information on the control boards necessary.

E. Professionalism, Summary of Shift, Comments

- 1. Peak shift turnover was very good. the PSN and APSN took control of overall plant operation in a very positive manner.
- 2. There was a problem involving a conflict between the application and interpretation of interim and current Tech. Specs. today. The Tech. Spec. section involved concerned Emergency Diesel Generators. A lack of understanding of the relationship/differences between the interim and current Tech. Specs. caused unnecessary concern over possibly not having complied with the more conservative of the two Tech. Specs. This event further points out the need for formalized training for licensed operators, before they get to the control room, on the format and nature of the Interim Tech. Specs. This item was referred to in the MOS report for 4/13/88.

F. Recommendations

Discussions with Operations and Maintenance Departments supervision have been most encouraging concerning focusing on making PTN an Operations-oriented plant. However, these goals are not clearly evident to the everyday PTN worker. Making these goals evident to the everyday PTN workers will help them to be more accountable which will then make PTN a better plant.

Completed By: Charlie Stack
MOS Observer

Date: 04/14/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/15/88

Management Review By:

MS 14/14/88 MS 14/15/88 [Signature] 4/15/88
PM-N Date SVR Date VP Date

Date Started <u>04/14/88</u>	PSN MOS	Date Finished <u>04/14/88</u>
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Initiating PSN Anderson PSN _____ Completed PSN Salkeld
Initiating APSN Singer APSN _____ Completed APSN Guyer

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Area(s) for Improvement/Recommendations/Action Taken

O-ADM-021, Section 8.8.1.1.a.1 requires both Emergency Diesel Generator's (EDG) be tested within four hours of taking a Startup Transformer out-of-service and at least once per 24 hours thereafter. O-OSP-23.1 is the procedure used to satisfy the EDG operability testing requirements of current Tech. Spec. 4.8.1.a, which is much more extensive than required by O-ADM-021 to "demonstrate operability". O-OSP-23.1 takes approximately 2½ hours per EDG to complete thus making it impossible to satisfy the four hour requirement of O-ADM-021. It is suggested that either O-ADM-021 be revised to conform to current Tech. Specs. thus deleting the EDG testing requirements with a Startup Transformer out-of-service; or, O-OSP-23.1 be revised to incorporate an abbreviated test which is used whenever daily EDG testing is required which minimizes the wear and tear on the EDG. The APSN has written a O-ADM-021 feedback form detailing several ambiguous areas of this section.

C. Good Practices/Professionalism Observed

No comment

Reviewed By *L. P. [Signature]* Date 4/15/88 Actions Completed _____ Date _____

Date Started <u>04/14/88</u>	PSN MOS	Date Finished <u>04/15/88</u>
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Initiating PSN Anderson PSN _____ Completed PSN _____
 Initiating APSN Reese APSN _____ Completed APSN _____

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Action Taken

Tonight we prepared, as per I&C requirements presented at the shift meeting, to take valve FCV-498 out-of-service on a hand loader to repair the air regulator. This required us to temporarily lift a clearance on the steam dumps to condenser in case of a trip and to open the feedwater bypass valve to 50% so as to regulate feedwater flow while the main Feedwater control valve was on a handloader. I&C was then notified and said they were ready to do the work. It then took two and one half hours to obtain a TSA for the hand loader and to get a new pressure gauge from Stores and calibrate it prior to going on the hand loader and adjusting the air regulator.

There has been other instances lately of equipment being taken out-of-service on clearances only to be put back in service without the work being done because no one obtained parts prior to the equipment being taken out-of-service.

There also has been instances of OSP's that are brand new being performed on a unit in which when they were started, bistables pulled and so on; then it was found that they were not workable and the procedure had to be backed out of, bistables and other equipment restored, so that time could be spent fixing the procedure. The point is that with a little preparation; such as obtaining parts, having all paperwork ready, and reviewing procedures thoroughly prior to having equipment removed from service, would eliminate all this extra work and reduce the time the unit is in jeopardy.

C. Good Practices/Professionalism Observed

None

Reviewed By *R. Reese* Date 4/15/88 Actions Completed _____ Date _____

To: Operations Superintendent - Nuclear

Date: 04/15/88

From: Charlie Stack
(MOS Observer)

Shift: Day
 Night

A. Plant evolutions observed

- o Mid shift
 - End of shift briefing
- o Day Shift
 - Unit 3, 100% power, Normal operation, Moisture Separator Reheater test in progress
 - Unit 4, 100% power, normal operation
 - Shift briefing
 - PSN tour
 - Shift turnover
- o Peak shift
 - Unit 3, 100% power, normal operation
 - Unit 4, 100% power, normal operation
 - Shift briefing

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None

E. Professionalism, Summary of Shift, Comments

None

F. Recommendations

None

Completed By: Charlie Stack
MOS Observer

Date: 04/15/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/18/88

Management Review By: [Signature] 14/15/88 [Signature] 14/18/88 1

PM-N Date SVP Date VP Date

To: Operations Superintendent - Nuclear

Date: 04/15-16/88

From: Dennis H. Borgmann
(MOS Observer)

Shift: Day
 Night

A. Plant evolutions observed

- Moisture Separator Reheater
- End of peak shift meeting
- APSN/PSN shift turnover
- Midnight pre shift brief

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

1. Entry of PWO information into the Nuclear Job Planning System (NJPS) computer. The persons entering the data into the computer are not entering all the required information. One area in particular that was left off of several PWO's is the component tag number.

E. Professionalism, Summary of Shift, Comments

1. The peak shift PSN spent a considerable amount of time correcting and completing PWO's in the NJPS. He should have been only reviewing and approving but the data was incomplete or incorrect.
2. The PSN/APSN turnover was conducted systematically and professionally with a good exchange of information (very concise and item by item).

F. Recommendations

1. Remind all persons using the NJPS to use the total equipment data base (component tag numbers) when entering PWO's.

Completed By: Dennis H. Borgmann
MOS Observer

Date: 04/15-16/88

Reviewed By: *[Signature]*
Operations Superintendent - Nuclear

Date: 4/15/88

Management Review By: *[Signature]* *[Signature]* *[Signature]* *[Signature]*
PM₃N Date SVP Date VP Date
Date: 4/18/88
Date: 04/15-16/88

To: Operations Superintendent - Nuclear

Date: 04/15-16/88

From: Vito A. Kaminskas
(MOS Observer)

Shift: Day
 Night

A. Plant evolutions observed

- Units 3 & 4 at 100% power
- MWe Vs Backpressure Test, Unit 3
- Restart of plant computer (DDPS)
- PWO planning process, I&C
- Toured Nitrogen Auxiliary Feedwater Backup Station

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None

E. Professionalism, Summary of Shift, Comments

1. T. Reese (APSN) conducted an excellent shift meeting. The meeting was informative, concise and professional.
2. Technical Department Staff showed excellent dedication by successfully completing the MWe Vs Backpressure Test on Unit 3.

F. Recommendations

Continue to manage the plant in a manner that ensures safe operation.

Completed By: Vito A. Kaminskas
MOS Observer

Date: 04/15-16/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/18/88

Management Review By: [Signature] 14/18/88 [Signature] 14/18/88 [Signature] 14/18/88

PM-N Date SVP Date VP Date

Date Started <u>04/15/88</u>	PSN MOS	Date Finished <u>04/15/88</u>
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Initiating PSN <u>Schimkus</u>	PSN _____	Completed PSN <u>Schimkus</u>
Initiating APSN <u>Murphy</u>	APSN _____	Completed APSN <u>Murphy</u>

A. Questionable Work Practices/Actions Taken/Recommendations

Please see attached PWO. This PWO was presented for approval to start and was approved under the assumption that work on the Gland Steam Condenser would be of no consequence for plant conditions. A short time later Unit 3 RCO noted a Condenser low vacuum alarm. Subsequent investigation found I&C working on PS-3614, Low Vacuum Turbine Trip Pressure Switch. By following MI-89-001 a Turbine trip was averted.

Recommendations: Have GEMS Planner review PWO and ensure that equipment name or description is accurate prior to sending package out in field. I&C specialist should also be aware of equipment being worked on.

B. Area(s) for Improvement/Recommendations/Actions Taken

1. PSN gave impression to MOS at pre-shift briefing (0845) that I did not totally support the management effort of disciplinary action taken on 4/9/88 concerning 3A Intake Cooling Water (ICW) Strainer incident. Having been gone on a company project in Baltimore, Maryland, I returned to shift and felt it compulsive to discuss the incident with an understanding attitude of how the incident evolved, stress procedural compliance, form a means for operators to place input into questionable procedure steps, and especially open a door to allow myself to have one on one discussions with each operator on shift today. Unfortunately my attempt became side-tracked due to MOS comments to my Superintendent and immediate Supervisor.

Recommend: MOS please be more compassionate towards attempts by PSN's to open a two way door between bargaining unit employees and management for the sake of adverting operating problems.

Actions taken: Had one on one discussions with field operators with MOS present.

2. It was discovered that 3A Intake Cooling Strainer was removed from service with 3C ICW Pump out-of-service. This placed the unit in Tech. Spec. 3.0.1. due to both components are not allowed in these configurations at the same time.

Recommend: A change to 3/4-OP-019 be made to direct the operator to ensure that three ICW pumps are in service prior to strainer backwash.

Actions taken: Notified Operations Supervisor and Licensing. Returned equipment back to service. Notified PUP.

C. Good Practices/Professionalism Observed

Nuclear Operator/NWE worked as a team to identify and mitigate a blown seal on 3A Boric Acid Transfer Pump. Corrective actions by these individuals prevented a unit shutdown due to minimum equipment requirements.

Reviewed By [Signature] Date 4/15/88 Actions Completed _____ Date _____

Date Started 04/15/88

PSN MOS

Date Finished 04/16/88

Initiating PSN Anderson PSN _____ Completed PSN _____

Initiating APSN _____ APSN _____ Completed APSN _____

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism Observed

None

Reviewed By [Signature] Date 4/15/88 Actions Completed _____ Date _____

To: Operations Superintendent - Nuclear

Date: 04/16/88

From: Charlie Stack
(MOS Observer)Shift: Day
 Night**A. Plant evolutions observed**

- Mid shift
 - Turnover to day shift
 - Unit 3, 100% power, normal operation
 - Unit 4, 100% power, normal operation
- Day Shift
 - Shift briefing
 - Unit 3, 100% power, normal operation
 - Unit 4, 100% power, normal operation
 - Turnover to peak shift
 - PSN walkthrough plant, primary and secondary
- Peak shift
 - Shift brief
 - Unit 3, 100% power, normal operation
 - Unit 4, 100% power, normal operation

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

1. An additional SRO is required to manage Tech. Spec. configuration; specifically when looking at what PWO's are being worked by the Maintenance, Technical, and Operations Departments concurrently. Currently, the PSN, APSN, and NWE do not always have the time to approve, work and track the PWO's worked simultaneously by various PTN groups. An additional SRO/scheduler would help alleviate many potential Tech. Spec. Limiting Conditions for Operations from arising.
2. Procedure writing....As good a job as PUP does, the procedures issued by them should be cycled to Operations for a human factors evaluation inclusive of a trial implementation. The end product would be even better.
3. Logs, specifically Turbine Operator logs, should have a human factors approach in their organization such as having the order of the readings reflect the order in which an operator encounters them on a round about his/her area of responsibility.

E. Professionalism, Summary of Shift, Comments

1. Day shift watch turnover was very good. Plant status was detailed to all present.
2. Peak shift watch turnover was satisfactory.
3. Frustration is running high amongst those peak shift non-licensed personnel observed today. They in fact the entire Operations staff, possess good watch standing skills, and they usually exhibit a good knowledge of good engineering practices. These personnel have been under a microscope in recent months. They need to know and be reminded that management understands what they've been through, but good job performance is still the expectation.
4. The PSN is noted to be extremely effective today in conveying management positions to shift personnel. Consistency in management objectives and in seeking those objectives is the first step towards PTN returning to a well run, good performing plant. The management objective discussed today was procedural compliance. The PSN conveyed management's stance on this in a strong, concise fashion.

F. Recommendations

1. Plant material conditions - see PSN/MOS report for this date.
2. If the Operations Department is going to have responsibility for making electricity safely, then they ought to control directly anything that influences that. Testing should be controlled and conducted by Operations. To accomplish this, a larger personnel compliment is mandatory. An SRO should be the scheduler, and the PSN and APSN should be able to manage the shift without themselves becoming involved in small specific tasks in day to day operation of the PTN units.
3. The road back to normal operation at PTN is a long one. Upper level management must take a fairer share of the responsibility for the site's past failures while worker and staff attitudes heal, permitting more professionalism to emerge, better attitudes to develop and reliable productivity to increase. PTN's people are its hidden strength.

Completed By: Charlie Stack Date: 04/16/88
MOS Observer

Reviewed By: *Lee Pearce* Date: 4/17/88
Operations Superintendent - Nuclear

Management Review By: *CPB* *14/17/88* *MD* *4/18/88* *1*
PM-N Date SVP Date VP Date
04/16/88

To: Operations Superintendent - Nuclear

Date: 04/16-17/88

From: Dennis H. Borgmann
(MOS Observer)

Shift: Day
 Night

A. Plant evolutions observed

- Steam Generator levels periodic test
- End of shift meeting
- Beginning of shift meeting

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None

E. Professionalism, Summary of Shift, Comments

No comments

F. Recommendations

None

Completed By: Dennis H. Borgmann
MOS Observer

Date: 0416-17/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/18/88

Management Review By: [Signature] 4/18/88 [Signature] 4/18/88 [Signature] 4/18/88

PM/N Date SVP Date VP Date

To: Operations Superintendent - Nuclear

Date: 04/16-17/88

From: Vito A. Kaminskas
(MOS Observer)Shift: Day
 Night

A. Plant evolutions observed

- Unit 3 & 4, 100% power operations
- Valve watch program, CV-2201
- Component Cooling Water Heat Exchanger Test results
- Adjustments to Generator Hydrogen Cooler
- Control Room log reading

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None

E. Professionalism, Summary of Shift, Comments

Turkey Point personnel have shown great improvement in the area of professionalism during the last several months.

F. Recommendations

Need to find a better way to fill Primary Lab Water Tank.

Completed By: Vito A. Kaminskas
MOS Observer

Date: 04/16-17/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/18/88

Management Review By: [Signature] 4/18/88
PM/N Date SVP Date VP Date

Date Started 04/16/88

PSN MOS

Date Finished 04/16/88

Initiating PSN Schimkus PSN _____ Completed PSN Schimkus

Initiating APSN Murphy APSN _____ Completed APSN Murphy

A. Questionable Work Practices/Actions Taken/Recommendations

1. A ladder was leaning against "3B" Moisture Separator Reheater (MSR) timing valve inlet steam line and not secured at top. Safety concern. I had the ladder removed. It appears the ladder was used for MSR efficiency test.
2. Found metal scaffold board on Unit 3 Turbine Lube Oil Reservoir Upper Cooler with bottom of ladder being supported by Fire System spray nozzles. This scaffold belongs to painters. I had Maintenance remove scaffold board.

B. Areas for Improvement/Recommendations/Actions Taken

1. 3A Intake Cooling Water (ICW) motor/pump was removed from service for Motor Preventative Maintenance Surveillance (PMS) prior to day shift. On day shift PSN/APSN pre-shift briefings, Electrical Department was asked when work would commence. It was not scheduled for day shift although clearance request was for day shift. Electrical immediately changed work priorities to work PMS on motor.

Recommend: That better coordination be exhibited between Operations and Maintenance (especially since this is Tech. Spec. Limiting Condition for Operations equipment) in scheduling work activities.

C. Good Practices/Professionalism Observed

1. The Nuclear Operator, who recently received disciplinary action concerning procedural compliance while backwashing ICW Strainers, today returned to work. He openly shared his experience with three different shifts at our shift briefings. He was positive, showed sincere concern for the occurrence and solicited all operators to please not allow similar incidents to occur. He thanked management for the opportunity to return to work, and said he would continue passing on this experience to his fellow operators.

Reviewed By D.W. Kline Date 4/18/88 Actions Completed _____ Date _____

Date Started 04/16/88

PSN MOS

Date Finished 04/17/88

Initiating PSN Anderson PSN _____ Completed PSN _____

Initiating APSN _____ APSN _____ Completed APSN _____

A. Questionable Work Practices/Action Taken/Recommendations

None

B. Area(s) for Improvement/Recommendations/Action Taken

Ever since the Demineralized Water Storage Tank (DWST) System was installed in this plant, we have had a real headache filling the Primary Lab. Water Tank. The way the Lab Tank fill is supposed to work is upon low level, a switch opens a solenoid valve allowing water pressurized from the Water Treatment Plant (WTP) to flow into the tank and upon high level this valve automatically closes. Since the DWST System has been in service, there is no longer enough back pressure in the water line to push the water into this tank. For 4 or 5 years now we have had to throttle back to almost zero flow on the fill line to the DWST in order to force water up to the Lab Tank. This not only requires extra man hours worked; but also, in times of low water levels in the DWST, it unnecessarily jeopardizes the units by lessening the flow during the time the Lab Tank is being filled. Also we need to look at the time lost and trouble caused by bursting Ecolo Chem trailer rupture disks while performing this evolution. This has been such a problem that now when we need to fill the Lab Tank with the WTP out-of-service, we do not even use the Ecolo Chem trailer but go through a major valve alignment evolution to use primary water to fill the Lab Tank. The fill of the tank is usually done at least twice per day. Another thing to look at is a recent INPO finding at this plant concerning writing procedures to work around broken equipment or systems that do not work properly. Every procedure we have connected with filling the Lab Tank does this.

Recommend: With all these problems it is surprising that a simple inexpensive fix is all that is required to remedy this problem. We could install a very small booster pump on the secondary plant (to avoid altering safety-related systems). This pump could start and stop from the same level switches that operate the solenoid fill valve which would eliminate any evolution to fill this tank. The tank would always be automatically filled with no operator action and no interruptions to the laboratory or secondary water supplies.

C. Good Practices/Professionalism Observed

None

Reviewed By [Signature] Date 4/18/88 Actions Completed _____ Date _____

To: Operations Superintendent - Nuclear

Date: 04/17/88

From: R. C. Coulthard
(MOS Observer)

Shift: Day
 Night

A. Plant evolutions observed

- Relieved Charlie Stack at 10:00 A.M. who departed site due to illness.
- Unit 3 and 4 at 100% power with no abnormal operational evolutions
- Peak shift turnover meeting. Routine except for discussion of conduct of the procedure for filling the Spent Fuel Pit on previous peak shift

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for Improvement

None noted

E. Professionalism, Summary of Shift, Comments

Verbatim compliance with procedures is an issue again causing stress and discontent among the Nuclear Operators and Turbine Operators. A method has been established for all procedures that are operationally oriented to be walked through by the operators prior to going to the PNSC for approval. This should improve the practicality of the procedures and give the operators some "ownership" in the procedure when it is released for use.

F. Recommendations

None

Completed By: R. C. Coulthard
MOS Observer

Date: 04/17/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/18/88

Management Review By: [Signature] 11/13/83 [Signature] 14/18/88 1

PM-N Date SVP Date VP Date

To: Operations Superintendent - Nuclear

Date: 04/17-18/88From: Dennis H. Borgmann
(MOS Observer)Shift: Day
 Night**A. Plant evolutions observed**

- Plant tour with PSN (secondary)
- End of shift meeting
- Beginning of shift meeting

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None

E. Professionalism, Summary of Shift, Comments

1. During the weekend the Unit 4 Spent Fuel Pool was filled. In order to fill it, an OTSC was generated because the normal fill paths were unavailable. A problem resulted in completing the paperwork and has been identified in the PSN MOS report. The PUP group and the PNSC should make sure OTCS's are user friendly and intentions are clear.
2. The PSN MOS Report should be called something else, possibly the PSN Shift Report. It should also be more internal, PTN management only, and follow the guideline already established.

F. Recommendations

1. FPL should consider establishing a periodic peer evaluation, similar to the INPO peer evaluator program, between PTN and PSL. It could be a voluntary program for the participants and probably result in a good exchange of information and ideas.
2. Fix equipment, in lieu of rewriting procedures, examples:
 - a. Filling the Spent Fuel Pool with a hose instead of fixing valves.
 - b. Manual makeup to the Condensate Storage Tank (CST) in lieu of fixing CST Level Control System.
 - c. Taking local radiation readings in lieu of fixing Area Radiation Monitoring System (ARMS).
 - d. Filling the Gas Stripper Hotwell prior to purging Volume Control Tank in lieu of fixing vent header valves.

These were just a few that were identified by the mid shift crew.

Completed By:

Dennis H. Borgmann
MOS Observer

Date: 04/17-18/88

Reviewed By:

[Signature]
Operations Superintendent - Nuclear

Date: 4/18/88Management
Review By:

[Signature] [Signature] [Signature] 4/18/88 1
PM/N Date SVR Date VP Date

04/17-18/88

To: Operations Superintendent - Nuclear

Date: 04/17-18/88

From: Vito A. Kaminskas
(MOS Observer)

Shift: Day
 Night

A. Plant evolutions observed

- Units 3 and 4, 100% power operation
- Changing Switchyard voltage
- Routine log readings
- Temporary Status Alterations Quarterly review
- Toured intake area
- Toured Secondary plant

B. Immediate safety problems

None

C. Questionable work practices

None

D. Area(s) for improvement

None

E. Professionalism, Summary of Shift, Comments

PSN and APSN handled all problems on their shift as they became known in a fast and efficient manner.

F. Recommendations

None

Completed By: Vito A. Kaminskas
MOS Observer

Date: 04/17-18/88

Reviewed By: [Signature]
Operations Superintendent - Nuclear

Date: 4/18/88

Management Review By: [Signature] 1/1/88 [Signature] 4/18/88 [Signature] 1/1/88

PM/N Date SVP Date VP Date

Date Started 04/17/88

PSN MOS

Date Finished 04/17/88

Initiating PSN Schimkus PSN _____ Completed PSN Schimkus

Initiating APSN Murphy APSN _____ Completed APSN Murphy

A. Questionable Work Practices/Actions Taken/Recommendations

Found numerous missed sign offs in 4-OSP-033 (Filling the Spent Fuel Pit) which was started on 4/16/88 at 6:11 P.M. Procedure was satisfactorily performed with the help of OTSC's. However, it appeared the procedure should have been terminated until OTSC's were corrected to allow the off-normal alignment needed.

Recommendations:

More accountability of persons performing procedure to ensure correctness and completeness prior to review by PSN.

Actions taken:

1. Wrote report to Operations Superintendent and Operations Supervisor and discussed per telecom. Requested they confer with operators on this subject.
2. Held conference with all operators involved, stressed procedural compliance and more awareness to detail.

B. Areas for Improvement/Recommendations/Actions Taken

None

C. Good Practices/Professionalism, Observed

Operators performed their job tasks in a professional manner on both day and half of peak shift to which I was assigned.

Received numerous comments on equipment performance and suggestions for better performance.

Reviewed By [Signature] Date 4/15/88 Actions Completed _____ Date _____

Date Started <u>04/17/88</u>	PSN MOS	Date Finished <u>04/18/88</u>
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Initiating PSN Anderson PSN _____ Completed PSN _____

Initiating APSN _____ APSN _____ Completed APSN _____

A. Questionable Work Practices/Actions Taken/Recommendations

None

B. Areas for Improvement/Recommendations/Actions Taken

With INPO coming for another visit, I think we should look at a past INPO finding which still exists to some extent here at Turkey Point. This concerns using procedures to work around broken equipment. Examples of this are:

1. We have for years filled the Condensate Storage Tanks via the bypass valves around the automatic fill valves as per procedure 3/4-OP-018.1, because the level control does not work and the Level Control Valves leak through.
2. We are getting in the habit now of using a portable diesel air compressor for breathing air as per OP-15650, because we cannot keep the Breathing Air Compressors in service.
3. Almost all Turbine Plant Cooling Water automatic valves are controlled manually and have been as long as I can remember.
4. CV 1400, Condensate recirculation back to the Hotwell, is always functional only in manual.
5. The Desuperheater is always run manually.
6. Lab Tank fill (see 4/16-17/88 PSN MOS report) is not possible in automatic.
7. The Boric Acid Blenders on both units have not run automatically for at least 10 years.

I could go on and on with this list of things that are accepted as normal operations, but originally were not supposed to be. This is due to giving up on making a piece of equipment work as it was originally designed. I hope as each weekly system of the week is addressed, these forgotten about abnormalities will be looked into. I suggest that as each week's system-of-the-week is reviewed that it be discussed thoroughly with the field operators in charge of the system and the RCO's.

C. Good Practices/Professionalism Observed

None

Reviewed By [Signature] Date 4/18/88 Actions Completed _____ Date _____