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SUBJECT: Responds to violations noted in Insp Repts 50-250/90-18 & 50-251/90-18.

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P.O. Box 14000, Juno Beach, FL 33408-0420

AUGUST 1 0 1990

L-90-290
10 CFR 2.201

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Gentlemen:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Reply to Notice of Violation
NRC Inspection Report 90-18

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

Very truly yours,

J. H. Goldberg
President
Nuclear Division

JHG/GRM/sh

Attachment

cc: Stewart D. Ebneter, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

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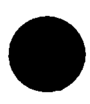


ATTACHMENT

REPLY TO NOTICE OF VIOLATION

RE: Turkey Point Units 3 and 4
Docket Numbers 50-250 and 50-251
NRC Inspection Report 90-18

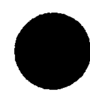
FINDING

TS 6.8.1 requires the written procedures and administrative policies shall be established, implemented and maintained that meet or exceed the requirements and recommendations of Appendix A of USNRC Regulatory Guide 1.33 and Sections 5.1 and 5.3 of ANSI N18.7-1972. Section 5.1 of ANSI N18.7-1972 requires that procedures be followed. 4-OSP-089, Section 7.2.59, Main Turbine Valves Operability Test, authorizes the operator to continue the startup per the applicable GOP. ADM-200, Conduct of Operations, revision dated March 1, 1990, specified that the Plant Supervisor Nuclear (PSN) was responsible for directing unit operations during routine plant operation.

Contrary to the above, in the two examples cited below, the licensee failed to follow procedures.

1. On May 26, 1990, Unit 4 was inadvertently manually tripped while at approximately 1% power during the performance of 4-OSP-089. The licensee was in the process of performing step 5.2.59, which states: "Trip the Reactor Trip Breakers or continue plant startup in accordance with the requirements of the applicable GOP (N/A if breakers were not reset in step 7.2.8)." With the PSN's concurrence, the Reactor Control Operator (RCO) tripped the reactor trip breakers resulting in a reactor trip in lieu of continuing with the startup as intended.

2. On June 15, 1990, the PSN did not adequately direct the Unit 3 RCOs, as specified in ADM-200, while the unit was being taken offline. This allowed poor communication between the RCOs controlling the reactor and the turbine. The poor communication led to the RCO pulling control rods to raise RCS Tavg as the turbine was being tripped. This resulted in reactor power increasing above the P-10 setpoint (10% reactor power) which automatically tripped the reactor.



RESPONSE TO THE FINDING

EXAMPLE 1

1. FPL concurs with the finding.

2. The cause for the manual reactor trip is a cognitive error made by a licensed utility individual. Step 7.2.59 of procedure 4-OSP-089 offered two options to the Reactor Control Operator (RCO). The first option was to trip the reactor. The second option was to continue on with the plant startup in accordance with the General Operating Procedures (GOPs). The RCO erroneously chose the first option which was to trip the reactor. The RCO should have selected the second option which would have returned him to the GOP procedure to continue start-up of the unit.

   This event was reported to the NRC in Licensee Event Report 50-251/90-04.

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

   a. The unit was stabilized in Mode 3 (Hot Standby) in accordance with approved plant procedures.

   b. The event reported to the NRC in LER 50-251/90-04 was discussed during weekly Operations Department shift meetings with management personnel.

4. Corrective steps which will be taken to avoid further violations include:

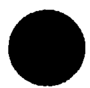
   a. Operating Surveillance Procedures 3/4-OSP-089 have been revised. The Plant Supervisor-Nuclear (PSN), now decides which option to exercise for Step 7.2.59.

   b. An Event Response Team (ERT) was formed to determine the root cause for the reactor trip and make recommendations to prevent recurrence. The ERT recommended formal operator training on self-checking. Scheduled training classes on self-checking were completed by July 31, 1990. However, several operators did not receive the training. Plant access will be denied for these individuals until they have received training on self-checking.

5. The date when full compliance was achieved:

   a. Item 3.a was completed on May 26, 1990.

   b. Item 3.b was completed on July 24, 1990.



c. Item 4.a was completed on June 5, 1990.

d. Item 4.b will be completed by August 31, 1990.

EXAMPLE 2

1. FPL concurs with the finding.

2. The cause for the automatic reactor trip is a cognitive error made by licensed utility personnel. Preparations were being made to manually trip the turbine as part of a controlled unit shutdown to repair an identified condenser tube leak. With reactor power below the P-10 permissive (less than 10% reactor power), one Reactor Control Operator (RCO) was attempting to correct a low Reactor Coolant System (RCS) average temperature (Tavg) condition by pulling control rods. In doing so, reactor power was increased to the P-10 permissive. A second RCO tripped the turbine without verifying the reactor and steam generators were in a stable condition below 10% reactor power.

   This event was reported to the NRC in Licensee Event Report 50-250/90-013.

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

   a. The unit was stabilized in Mode 3 (Hot Standby) in accordance with approved plant procedures.

   b. An entry has been made in the Operations Night Order Book to emphasize the need for Control Room Supervisors to establish themselves as the command/control focus of significant operating evolutions. This requires the Assistant Plant Supervisor-Nuclear (APSN)/Plant Supervisor-Nuclear (PSN) to ensure that specific evolution briefings are completed, that communications are accurate and adequate, and that evolutions are smooth and controlled.

4. Corrective steps which will be taken to avoid further violations include:

   a. Scheduled training classes on self-checking were completed by July 31, 1990. However, several operators did not receive the training. Plant access will be denied for these individuals until they have received training on self-checking.

   b. This event will be reviewed with applicable operations personnel to increase awareness of the potential for undesirable results due to a failure to mentally review the consequences of actions being performed. In

addition, the necessity of adequate communications between the different operators and the PSN is being stressed during this review since inadequate communications were determined to have been a significant contributing cause of this event.

c. An Operations Department Instruction will be issued to clarify those evolutions which require pre-job briefings. Additionally, the instruction will define those tasks requiring assignment of a dedicated individual responsible for evolution oversight.

5. The date when full compliance was achieved:

a. Item 3.a was completed on June 15, 1990.

b. Item 3.b was completed on June 15, 1990.

c. Item 4.a will be completed by August 31, 1990.

d. Item 4.b will be completed by August 31, 1990.

e. Item 4.c will be completed by August 31, 1990.