



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET SW SUITE 23T85
ATLANTA, GEORGIA 30303-8931

April 21, 2000

Florida Power and Light Company
ATTN: Mr. T. F. Plunkett
President - Nuclear Division
P. O. Box 14000
Juno Beach, FL 33408-0420

SUBJECT: NRC INTEGRATED INSPECTION REPORT 50-335/00-02, 50-389/00-02

Dear Mr. Plunkett:

This refers to the inspection conducted on February 13 through April 1, 2000, at the St. Lucie 1 and 2 reactor facilities. The enclosed report presents the results of that inspection.

During the inspection period, your conduct of activities was generally characterized by safety conscious operations.

Based on the results of the inspection, the NRC has determined that one violation of NRC requirements occurred. This violation is being treated as a Non-Cited Violation (NCV), consistent with Section VII B.1.a of the NRC Enforcement Policy. The NCV is described in the subject inspection report. If you contest the violation or severity level of the NCV, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001, with copies to the Regional Administrator, Region II, the Resident Inspector at your facility, and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington DC 20555-0001.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room (PDR).

Sincerely,

/RA/

Leonard D. Wert, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Docket Nos. 50-335, 50-389
License Nos. DPR-67, NPF-16

Enclosure: Inspection Report Nos. 50-335/00-02, 50-389/00-02

cc w/encl: (See page 2)
cc w/encl:

Rajiv S. Kundalkar

FPL

2

Plant Vice President
Florida Power & Light Company
Electronic Mail Distribution

R. G. West
Plant General Manager
St. Lucie Nuclear Plant
Electronic Mail Distribution

E. J. Weinkam
Licensing Manager
St. Lucie Nuclear Plant
Electronic Mail Distribution

John Gianfrancesco, Manager
Administrative Support & Special Projects
Florida Power & Light Company
Electronic Mail Distribution

Mark Dryden
Administrative Support & Special Projects
Florida Power & Light Company
Electronic Mail Distribution

J. A. Stall
Vice President - Nuclear Engineering
Florida Power & Light Company
P. O. Box 14000
Juno Beach, FL 33408-0420

M. S. Ross, Attorney
Florida Power & Light Company
Electronic Mail Distribution

William A. Passetti
Bureau of Radiation Control
Department of Health
Electronic Mail Distribution

Joe Myers, Director
Division of Emergency Preparedness
Department of Community Affairs
Electronic Mail Distribution

J. Kammel
Radiological Emergency
Planning Administrator
Department of Public Safety
Electronic Mail Distribution

Douglas Anderson
County Administrator
St. Lucie County
2300 Virginia Avenue
Ft. Pierce, FL 34982

Distribution w/encl:
K. Jabbour, NRR
PUBLIC

OFFICE	RII:DRP	RII:DRP	RII:DRP	RII:DRS	RII:DRS	RII:DRS	
SIGNATURE	<i>TRoss</i>	<i>TRoss for</i>	<i>GWarnick</i>	<i>JKreh for</i>	<i>JKreh</i>	<i>GSalyer</i>	
NAME	<i>TRoss</i>	<i>DLanyi</i>	<i>GWarnick</i>	<i>WSartor</i>	<i>JKreh</i>	<i>GSalyers</i>	
DATE	4/18/00	4/18/00	4/17/00	4/19/00	4/19/00	4/19/00	4/ /2000
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 50-335, 50-389
License Nos: DPR-67, NPF-16

Report Nos: 50-335/00-02, 50-389/00-02

Licensee: Florida Power and Light Company

Facility: St. Lucie Nuclear Plant, Units 1 & 2

Location: 6501 South A1A
Jensen Beach, FL 34957

Dates: February 13 - April 1, 2000

Inspectors: T. Ross, Senior Resident Inspector
D. Lanyi, Resident Inspector
G. Warnick, Resident Inspector
W. Sartor, Senior Emergency Preparedness Inspector
(Section P4)
J. Kreh, Emergency Preparedness Inspector (Section P4)
G. Salyers, Emergency Preparedness Inspector (Section P4)

Approved by: L. Wert, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Enclosure

EXECUTIVE SUMMARY

St. Lucie Nuclear Plant, Units 1 & 2 NRC Inspection Report 50-335/00-02, 50-389/00-02

This integrated inspection included aspects of licensee operations, maintenance, engineering, and plant support. The report covers a 7-week period of resident inspection; in addition, it includes the results of an inspection by regional emergency preparedness inspectors.

Operations

- During a routine run of the 2B diesel generator, the primary control room indicator of generator electrical load became erratic. The diesel generator was inadvertently tripped on reverse current while operators were attempting to unload it. Operators did not fully recognize the effects of reactive loading on the diesel generator (Section O4.1).

Maintenance

- Maintenance work activities and surveillance testing were consistently performed in accordance with procedural requirements. Overall, operators, technicians, and journeymen were observed to be knowledgeable, experienced, and trained for the tasks performed (Section M1.1).
- Numerous performance problems occurred during the 2A emergency core cooling system Critical Maintenance Management (CMM) planning process. Several provisions of the administrative procedure governing CMMs were not met. Condition Reports initiated before the CMM was executed were not adequately resolved. Although the 2A High Pressure Safety Injection system was unavailable for longer than initially planned, system unavailability did not exceed the maintenance rule goal. A non-cited violation was issued for failure to follow established CMM procedures. Comprehensive corrective actions were developed to prevent recurrence of this problem (Section M1.2).

Plant Support

- The licensee's performance in responding to the simulated emergency during the biennial exercise on February 16, 2000 was satisfactory, and the exercise constituted a successful demonstration of the licensee's emergency response capabilities (Section P4.2).

Report Details

Summary of Plant Status

Both units remained at essentially full power for the entire report period.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (71707)

During the inspection period, the resident inspectors observed that overall, the conduct of operations was safety-conscious. Operators were attentive to changing plant conditions and their communications were effective. Operator responses to the inspectors' questions demonstrated understanding of plant design and knowledge of equipment status. Specific events and noteworthy observations are detailed in the sections below.

O1.2 New Fuel Transfer and Receipt Inspection (71707)

The inspectors observed the receipt of new fuel for the upcoming Unit 2 refueling outage and transfer of the fuel to the new fuel storage racks and spent fuel pool. Receipt inspections were properly conducted by a fuel vendor representative and a reactor engineer. Operators were knowledgeable of and followed Operating Procedure 1610020, Receipt and Handling of New Fuel and Control Element Assemblies. Appropriate records and logs were maintained during fuel inspections and transfers, and the level of supervision was also appropriate. No issues were identified.

O1.3 2B Main Feedwater (MFW) Pump Trip (71707)

On March 21, prompt actions by operators inside and outside the Unit 2 main control room effectively mitigated the consequences of a partial loss of MFW event when the 2B MFW pump tripped unexpectedly during 100% power operation. The 2B MFW pump tripped while a non-licensed operator (NLO) was hanging clearance tags on the root isolation valves for a pressure differential instrument (PDI) on the suction side of the pump. This tagout unintentionally isolated the 2B MFW suction side pressure switch resulting in a low pressure trip of the pump. Subsequent investigation by the licensee confirmed the clearance order and NLO actions were appropriate; but discovered that the instrument lines for the PDI and 2B MFW suction side pressure switch were inadvertently crossed during a previous modification many years ago. Timely actions by the NLO and control room operators were instrumental in returning the 2B MFW pump to service and restoring MFW flow. Initially, an event review team was assembled, but this effort was down-graded to a root cause team by the next day. Appropriate corrective actions were initiated to address the identified issues. The initial event review team was well organized and supported; the event investigation was thorough and methodical.

O2 Operational Status of Facilities and Equipment

O2.1 General Plant Tours And Safety Significant System Walkdowns (71707)

General tours of safety-related areas were performed by the inspectors to observe the physical condition of plant equipment and structures. In addition, the inspectors conducted specific walkdowns of the following safety significant systems:

- Unit 2 vital AC electrical distribution system
- Unit 2 fuel handling building ventilation system

Equipment operability, material condition, and housekeeping were acceptable in all cases. Several minor discrepancies were brought to the licensee's attention and were corrected. No issues were identified.

O2.3 Detailed Engineered Safety Feature System Walkdown (71707)

The inspectors performed detailed walkdowns of the Unit 1 low pressure safety injection (LPSI) system and Unit 2 emergency diesel generators (EDG). These systems are risk significant and in the scope of 10 CFR 50.65 (Maintenance Rule). The inspectors verified that system configurations, including valves, breakers, and switches, was consistent with plant line-up procedures, and system drawings. Technical Specifications (TS) and the Updated Final Safety Analysis Report were reviewed for accuracy and consistency, no discrepancies were identified. Recent surveillance records were also reviewed for completeness and TS compliance. Equipment operability, material condition, and housekeeping were observed to be acceptable. No issues were identified.

O4 Operator Knowledge and Performance

O4.1 Inadvertent Reverse Power Trip of the 2B Emergency Diesel Generator

a. Inspection Scope (71707 and 37551)

The inspector reviewed the circumstances surrounding an unintentional reverse power trip of the 2B EDG on February 23. This review consisted of evaluating the available data, reviewing the applicable procedures, and interviewing responsible Engineering and Operations personnel.

b. Observations and Findings

The reverse power trip occurred while the operators were unloading the 2B EDG after completion of a successful load run. A problem with the watt recorder in the main control room had occurred at the end of the load run. The Nuclear Plant Supervisor, Assistant Nuclear Plant Supervisor, and Reactor Control Operator discussed the status of the EDG and then decided on a deliberate course of action. They determined that they would need to use an alternate method for monitoring electrical load as they

unloaded the EDG (output current and local indication of power). The control room operators reduced EDG output current to approximately 200 amperes in anticipation that, at this current level, the diesel would be lightly loaded prior to opening the output breaker. However, the operators did not account for reactive loading, and the diesel tripped on reverse current after the programmed time delay. There was no damage to the diesel or the breaker.

Discussions with the operators indicated that they were aware that some reactive loading existed on the machine, but they apparently did not fully understand the magnitude of the reactive load. The operators did not completely use all of their available indications. Even though they did periodically verify real load locally and monitored electrical current while unloading the diesel, they did not fully recognize apparent changes in reactive load. The inspectors concluded that the operators complied with procedural requirements.

c. Conclusions

During a routine run of the 2B diesel generator, the primary control room indicator of generator electrical load became erratic. The diesel generator was inadvertently tripped on reverse current while operators were attempting to unload it. Operators did not fully recognize the effects of reactive loading on the diesel generator

O4.2 Equipment Clearance Order Implementation (71707)

The inspector observed the hanging and removal of Equipment Clearance Order 1-00-02-50, Qualified Safety Parameter Display System Inverter 1A. Additionally, the inspector verified the adequacy of the clearance with the appropriate plant drawings. Operations adequately prepared and administered the clearance.

O8 Miscellaneous Operations Issues

- O8.1 (Closed) LER 50-389/99-08: Improper Return of Reactor Protection System Channel Back in Service Results in Operation Prohibited by Technical Specifications. On December 14, 1999, the licensee determined that channel D of the reactor protection system (RPS) steam generator (SG) low level trip had been placed back in service without the post maintenance testing required by a temporary change to procedure 2-OSP-62.02, RPS Logic Matrix Test. The SG level trip for Channel D had been placed in bypass on December 7 due to a failed 2A SG level transmitter. A one-time temporary change was made to the logic matrix procedure to allow RPS testing with Channel D bypassed. This would allow the licensee to complete the TS surveillance requirements for the other RPS channels on December 9, prior to the expiration of the surveillance interval. The Channel D level transmitter was subsequently repaired and declared back in service on December 13. At which time, Channel D was taken from bypass to normal without performing the TS required logic matrix testing specifically called for by the temporary procedure change.

The inspector reviewed condition report 99-2499 written to address the event, and the associated root cause analysis. This analysis was comprehensive and thorough in

evaluating the event, determining root causes, and developing corrective actions. It accurately determined human error was the principal cause. Operations personnel did not use available administrative tools to effectively track the surveillance requirements of Channel D prior to returning it to service.

Consequently, Channel D was returned to service several days after its TS 4.3.1 surveillance requirements had expired. Technical Specification 3.3.1 states, "With the number of channel OPERABLE one less than Total Number of Channels, STARTUP and/or POWER OPERATION may continue provided the inoperable channel is placed in the bypassed or tripped condition within one hour." Contrary to this TS requirement, Channel D was not placed in bypass within an hour after being returned to service.

The inspectors concluded that this violation has very low safety significance. It was caused by an isolated human error and is not indicative of a programmatic deficiency. No other RPS SG level channels were inoperable during the one day interval. Once the missed surveillance test was identified, the required surveillance testing of RPS Channel D was promptly completed on December 14 within the time allowed by TS 4.0.3. This testing also verified the operability of the system since the time it was returned to service on December 13. Additionally, if the Channel D RPS SG level trips had been inoperable, the other three independent and redundant channels could have fulfilled the RPS initiating logic for a SG low level trip. Therefore, this issue constitutes a violation of minor significance and is not subject to formal enforcement action. This LER is closed.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Maintenance Work Order and Surveillance Observations

a. Inspection Scope (61726 and 62707)

The resident inspectors observed all or portions of the following maintenance and surveillance activities, including Work Orders (WO), Operating Procedures (OP), I&C Procedures (ICP), and Operations Support Procedures (OSP):

- WO 29000054 Installation of 1A Qualified Safety Parameter Display System Inverter Temporary System
- WO 30004695 Monthly Functional on the Unit 1 Particulate, Iodine, and Gas Monitor
- WO 30004694 Unit 2 Safety Injection Tank Functional
- WO 30003869 01 V09107 - Check Valve for 1A Auxiliary Feedwater (AFW) Pump Discharge
- WO 29020433 Level Indicator Controller for 2A Steam Generator
- WO 30003662 01 AFW Actuation System Monthly Functional
- 2-OSP-24.01 2A High Pressure Safety Injection System Leak Test
- OP-1-0700050 1C AFW Pump Post Maintenance Testing
- 2-ICP-1400064L 2A2 Safety Injection Tank Level Calibration Check

b. Observations, Findings, and Conclusions

All observed maintenance work activities and surveillance testing were performed in accordance with work instructions, procedures, and applicable clearance controls. Safety-related maintenance and surveillance testing evolutions were properly planned and executed. Licensee personnel demonstrated familiarity with administrative and radiological controls. Surveillance tests of safety-related equipment were consistently performed in a deliberate manner in close communication with the main control room. All Technical Specification action statements were appropriately entered and exited. Overall, operators, technicians, and journeymen were observed to be knowledgeable, experienced, and trained for the tasks performed.

Additional maintenance and surveillance activities are discussed in the following paragraphs.

M1.2 2A Emergency Core Cooling System Critical Maintenance Management

a. Inspection Scope (62707)

Inspectors evaluated the effectiveness of the critical maintenance management (CMM) process used to plan and implement on-line maintenance for the 2A emergency core cooling system (ECCS) that was conducted last inspection period (Inspection Report 2000-01, Section M1.1). Additionally, the inspectors reviewed the licensee post-implementation critique, and subsequent root cause analysis that addressed several problems.

b. Observations and Findings

A 2A ECCS CMM was planned and performed as voluntary on-line maintenance during February 8-10, 2000. Immediately following the CMM, the licensee held a critique to assess their performance. During the critique, numerous areas of improvement were identified, including some specific performance problems. Condition report (CR) 00-0216 was promptly initiated to perform a root cause analysis and formulate corrective actions to address the more significant CMM process failures that occurred. The inspectors reviewed the effectiveness of the 2A ECCS Critical Maintenance Management (CMM) process, and subsequent licensee self-assessment, due to the many problems that were experienced and the proximity of the CMM to the planned start of the next Unit 2 refueling outage.

The licensee's root cause analysis of CR 00-0216 identified several significant CMM process problems which did not meet the requirements of administrative procedure ADM-10.01, Critical Maintenance Management:

- The 18 week CMM planning process was essentially suspended for several weeks due to inadequate communications with management. Planning recommenced only five weeks prior to the scheduled work date. The NRC inspectors also noticed that the CMM planning process had begun two to three weeks later than required by the procedure, primarily due to the Unit 1 refueling outage.

- Operations/Clearance personnel did not attend the CMM planning meetings and were not directly involved with the CMM process until the week before execution. The NRC inspectors also concluded that the level and detail of supervisory oversight and management support of the 2A ECCS CMM process failed to fulfill established program responsibilities of ADM-10.01, Section 3.3 and 3.4.
- The work scope of critical activities used to justify the CMM was reduced late in the process without required notification and review by System Component Engineering. The inspectors further noted that the final scope of work activities for the 2A High Pressure Safety Injection (HPSI) train used to justify the 2A ECCS CMM did not meet the guidelines of ADM-10.01, Section 6.0 for adding reliability.

In addition, the licensee's Facility Review Group identified that two CRs written by Work Control personnel earlier in the CMM planning process were not properly dispositioned. The responses were superficial and did not sufficiently address the deficiencies. These CRs were initiated when personnel integrally involved in the process became concerned that the planning process for the 2A ECCS CMM had departed considerably from the established administrative requirements of ADM-10.01. The inadequate resolution of these CRs was subsequently incorporated into the root cause analysis. The inspectors noted that Work Control management was tasked to address the inadequate resolution of these CRs

Overall, the licensee's critique and completed root cause analysis provided a thorough, critical assessment of the 2A ECCS CMM process, and developed comprehensive corrective actions. After discussions with licensee management, and a review of the short and long term corrective actions, the inspectors determined that the actions taken, and those scheduled to be taken, should be sufficient to prevent recurrence of the aforementioned process problems.

During the 2A ECCS CMM, the 2A HPSI train unavailability hours was increased by approximately 42 hours. The original CMM schedule was only intended to take the 2A HPSI train out of service for about 17 hours. However, last minute rescheduling of work and some unexpected maintenance difficulties led to a considerable increase in unavailability. The HPSI system is the plant's highest risk system with a maintenance rule unavailability goal of 100 hours per train per year. Both the maintenance rule coordinator and the HPSI system engineer indicated that the 2A HPSI was not expected to exceed its unavailability goal due to this CMM. The total inoperability time of the affected safety systems during the 2A ECCS CMM remained well within the TS allowable outage time limits. The other train of ECCS equipment remained operable throughout the CMM.

Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained for the activities recommended in Appendix A of Regulatory Guide (RG)1.33, Revision 2, February 1978. Section 9.0 of this RG specifically recommends procedures for control of maintenance activities. Failure to follow ADM-10.01 for the 2A ECCS CMM planning process was a violation of TS 6.8.1.a. The violation occurred during the designated 18 week CMM planning process

prior to the first week of February 2000. This Severity Level IV violation is being treated as a Non-Cited violation, consistent with Section VII.B.1.a of the NRC Enforcement Policy, and is identified as NCV 50-389/00-02-01, Failure to Follow the Critical Maintenance Management Process for 2A ECCS On-line Maintenance. This violation was addressed in the licensee's corrective action program as CRs 00-62, 00-75, 00-0168, and 00-0216.

c. Conclusions

Numerous performance problems occurred during the 2A ECCS CMM planning process. Several provisions of the administrative procedure governing CMMs were not met. Condition Reports initiated before the CMM period was executed were not adequately resolved. Although the 2A HPSI system was unavailable for longer than initially planned, system unavailability did not exceed the maintenance rule goal. A non-cited violation was issued for failure to follow established CMM procedures. Comprehensive corrective actions were developed to prevent recurrence of this problem.

III. Engineering

E1 Conduct of Engineering

E1.1 Unit 1 Qualified Safety Parameter Display System Temporary System Alteration (37551)

The inspector reviewed the Engineering package for Temporary System Alteration 1-00-001 for the Unit 1 Qualified Safety Parameter Display System. This document was complete, clearly written, and provided technically correct information to achieve the intended results. All system interactions had been addressed and dispositioned.

E1.2 Low Pressure Safety Injection System Maintenance Rule Implications (37551)

The inspector verified that the licensee was properly tracking the performance of the Unit 1 low pressure safety injection system and that appropriate goals had been set. No findings were identified during this review.

IV. Plant Support

R1 Radiological Protection and Chemistry Controls

R1.1 Unit 1 Spent Resin Tank Transfer (71750)

On February 23, 2000, an inspector observed Health Physics (HP) and Operations personnel perform a resin transfer from the Unit 1 Spent Resin Tank to an approved container for shipment off-site. The resin transfer was performed per Health Physics Procedure HP-49A, Transfer of Radioactive Bead Resins. Adequate supervisory oversight was present throughout the transfer evolution. Personnel questioned by the inspector were knowledgeable of the precautions and guidance described in the procedure. The HP technicians were cautious during the preparation and transfer phases. They also conducted multiple checks for leaks and changing radiation levels throughout the process. The resin transfer was completed in a safety conscious manner.

P4 Staff Knowledge and Performance in Emergency Preparedness (EP)

P4.1 Review of Exercise Objectives and Scenario for Power Reactors (82302)

The complete scenario package was submitted to the NRC on December 13, 1999. The exercise scenario was of sufficient detail and challenge to demonstrate the exercise objectives and test the licensee's onsite and offsite emergency organizations.

P4.2 Evaluation of Exercises for Power Reactors (82301)

a. Inspection Scope

During the period of February 14-17, 2000, the inspectors observed and evaluated the St. Lucie Nuclear Power Plant biennial, full-participation emergency preparedness exercise as well as selected activities related to the licensee's conduct and self-assessment of the exercise. Licensee activities inspected during the exercise included those occurring in the Control Room Simulator (CRS), Technical Support Center (TSC), Operations Support Center (OSC), and Emergency Operations Facility (EOF). The inspectors evaluated licensee recognition of abnormal plant conditions, classification of emergency conditions, notification of offsite agencies, development of protective action recommendations, command and control, communications, adherence to Emergency Plan Implementing Procedures (EPIPs), and the overall implementation of the licensee's Emergency Plan. The exercise was conducted on February 16, 2000 from 7:00 a.m. to 1:50 p.m.

b. Emergency Response Facility (ERF) Observations and Findings

b.1 Control Room Simulator

The initiating event in this scenario commenced at 7:15 a.m., as a reactor coolant system leak. (Details regarding the exercise scenario may be found in a narrative

summary included in the attachment to this report.) The Nuclear Plant Supervisor (NPS) was effective as the Emergency Coordinator (EC) and turned over this responsibility to the Technical Support Center at 8:28 a.m.

b.2 Technical Support Center

The Control Room EC ordered the TSC activated following the Notification of Unusual Event (NOUE) emergency declaration. The TSC was staffed and activated within the required time. The EC established effective command and control. Briefings were scheduled on the hour and half-hour in which the TSC staff discussed changing plant conditions and immediate repair priorities. Each briefing lasted approximately ten minutes. The EOF and OSC were kept informed of changing plant conditions by monitoring the TSC briefings on closed-circuit television. Communication among the TSC participants was good, and plant status boards were updated as new data were received. The TSC made correct and timely Alert, Site Area Emergency (SAE) and General Emergency declarations and applicable offsite notifications as the initial simulated reactor coolant leak progressed to a loss of coolant accident.

The Problem Solving Team (PST) was pro-active and provided good support to the CRS and TSC staff. The PST was effective in analyzing problems and identifying potential success paths for the simulated system failures.

b.3 Operations Support Center

The inspector briefly observed activities at the OSC, and noted that the facility was well organized and that some team members were dressed-out to expedite the dispatch of high priority repair missions. The inspector did not observe the briefing or dispatch of any teams.

b.4 Emergency Operations Facility

At 8:06 a.m., following the NOUE declaration, the NPS/EC invoked the option of activating the TSC via a public address announcement. Because of the wording of this announcement, EOF activation (which was not required to commence until an SAE classification) was inadvertently initiated as well. The Recovery Manager (RM) provided an initial briefing to the EOF staff at 9:41 a.m. With the emergency still classified at the Alert level, the EOF was declared to be operational at 9:45 a.m.

Command and control of facility operations by the RM was proficient. Periodic briefings provided the staff with appropriate details as well as an overall perspective of the simulated event. The EOF staff functioned efficiently and professionally in executing the following primary responsibilities: communications with State, county, and Federal governmental authorities; development of protective action recommendations for the public; core damage assessment; and radiological assessment.

b.5 Licensee Exercise Critique

Following the exercise, the licensee conducted facility critiques in which the players assessed their own performance and identified areas for improvement. Subsequently, the licensee's controller/evaluator organization held detailed discussions and reviewed documentation to develop its critique results. The licensee's concise and substantive critique was presented to management on February 17, 2000.

c. Overall Exercise Conclusions

The licensee's performance in responding to the simulated emergency was satisfactory, and the exercise constituted a successful demonstration of the licensee's emergency response capabilities. Emergency declarations were correct and timely, and offsite notifications were initiated within 15 minutes. Command and control in each of the ERFs was effective. Staffing of emergency response facilities was timely.

V. Management Meetings and Other Areas

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on April 4, 2000. An interim exit meeting had been held on February 17, 2000 to discuss the findings of a Region based inspection. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

C. Bible, Site Engineering Manager
 G. Bird, Protection Services Manager
 W. Bladow, Maintenance Manager
 D. Calabrese, EP Supervisor
 R. De La Espriella, Site Quality Manager
 W. Guldemon, Operations Manager
 R. Kundalkar, Site Vice President
 C. Ladd, Operations Supervisor
 W. Lindsey, Training Manager
 E. Weinkam, Licensing Manager
 R. West, Plant General Manager
 C. Wood, Work Control Manager

Other licensee employees contacted included office, operations, engineering, maintenance, chemistry/radiation, and corporate personnel.

INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering
 IP 40500: Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems
 IP 61726: Surveillance Observations
 IP 62707: Maintenance Observations
 IP 71707: Plant Operations
 IP 71750: Plant Support Activities
 IP 82301 Evaluation of Exercises for Power Reactors
 IP 82302 Review of Exercise Objectives and Scenarios for Power Reactors
 IP 92901: Followup - Plant Operations

ITEMS OPENED AND CLOSED**Opened**

50-389/00-02-01 NCV Failure to Follow the Critical Maintenance Management Process for 2A ECCS On-line Maintenance. (Section M1.2)

Closed

50-389/99-08-00 LER Improper Return of Reactor Protection System Channel Back in Service Results in Operation Prohibited by Technical Specifications. (Section O8.1)

50-389/00-02-01 NCV Failure to Follow the Critical Maintenance Management Process for 2A ECCS On-line Maintenance. (Section M1.2)

Attachment: St. Lucie 2000 Emergency Preparedness
Evaluated Exercise