



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

April 16, 2004

EA-04-077

Florida Power and Light Company
ATTN: Mr. J. A. Stall, Senior Vice President
Nuclear and Chief Nuclear Officer
P. O. Box 14000
Juno Beach, FL 33408-0420

**SUBJECT: NRC OFFICE OF INVESTIGATIONS REPORT NOS. 2-2003-072 AND
2-2003-073 (ST. LUCIE NUCLEAR PLANT)**

Dear Mr. Stall:

Enclosed for your information are the synopses of two Nuclear Regulatory Commission (NRC) Office of Investigations (OI) completed reports. The investigations were conducted to review certain aspects of the St. Lucie Licensed Operator Continuing Training Program (LOCTP) associated with NRC license reactivation.

As documented in OI Report No. 2-2003-073, OI concluded that an Assistant Nuclear Plant Supervisor (ANPS) willfully failed to follow procedures associated with completing the plant tour section of the LOCTP. The NRC staff has completed its review of the OI report and conclusions, and has determined that a procedural non-compliance occurred. Specifically, on March 18, 2003, St. Lucie improperly certified that the requirements for reactivation of a Senior Reactor Operator (SRO) license had been met, when the SRO in question had not completed a plant tour of the areas required by Procedure 0005720, "Licensed Operator Continuing Training Program". Certification of qualifications, status of operator licensees (i.e., that they are current and valid) and that the specific requirements for license reactivation have been met prior to the resumption of licensed duties by licensed operators is required by 10 CFR 55.53.(f). Although a violation of regulatory requirements occurred, the NRC staff did not conclude that the ANPS's actions were willful.

The significance of the violation was evaluated using the NRC's Significance Determination Process, and was determined to be of very low safety significance (Green). In this case, the individual's failure to complete a plant tour prior to being placed on shift had little effect on his overall knowledge of plant operations or plant status, and additional watch standers were on shift who were cognizant of the current plant conditions when the individual was placed on watch. Because of the very low safety significance and because it was entered into your corrective action program, the NRC is treating this violation as a non-cited violation (NCV), in accordance with Section VI.A of the NRC's Enforcement Policy. Administratively, this NCV will be fully documented in an upcoming integrated inspection report, at which time St. Lucie may contest this NCV or provide any additional information.

Regarding OI Report No. 2-2003-072, the NRC staff has concluded that the actions of the SRO were not deliberate, and has determined that the circumstances in this case do not represent a violation of regulatory requirements.

Based on our review of the OI activity described in the synopses, we plan no further action with regard to these matters beyond the documentation matters as discussed above. Should you have any questions concerning this letter, please contact us.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Joel T. Munday, Chief
Reactor Projects Branch 3
Division of Reactor Projects

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

Enclosures: 1. Synopsis to OI Report 2-2003-072
2. Synopsis to OI Report 2-2003-073

cc w/encls: (See page 3)

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E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
PUBLIC DOCUMENT	YES NO						

SYNOPSIS

This investigation was initiated by the U.S. Nuclear Regulatory Commission (NRC) Office of Investigations, Region II, on October 3, 2003, to determine if a senior reactor operator (SRO) at the Florida Power and Light Company St. Lucie Nuclear Power Plant deliberately failed to provide complete and accurate information (not attaining the 40 hour training requirement) regarding the Licensed Operator Continuing Training Program procedure associated with an NRC license reactivation.

Based on the evidence, documentation, and testimony developed during this investigation, the allegation that the SRO falsified and/or deliberately misrepresented the 40 hour training requirement associated with an NRC license reactivation was not substantiated.

Approved for release on April 15, 2004 - SES

Enclosure 1

~~NOT FOR PUBLIC DISCLOSURE WITHOUT APPROVAL OF
FIELD OFFICE DIRECTOR, OFFICE OF INVESTIGATIONS, REGION II~~

SYNOPSIS

This investigation was initiated by the U.S. Nuclear Regulatory Commission (NRC), Office of Investigations, Region II, on October 3, 2003, to determine if an assistant nuclear plant supervisor (ANPS) at the Florida Power and Light Company St. Lucie Nuclear Power Plant (SLNP) deliberately failed to provide complete and accurate information (not completing the plant tour section) during the 40 hour training requirement) regarding the Licensed Operator Continuing Training Program (LOCTP) procedure associated with an NRC license reactivation.

Based on the evidence, documentation, and testimony developed during this investigation, the allegation that an ANPS willfully failed to follow procedures associated with completing the plant tour section of the LOCTP was substantiated.

Approved for release on April 15, 2004 - SES

Enclosure 2

~~NOT FOR PUBLIC DISCLOSURE WITHOUT APPROVAL OF
FIELD OFFICE DIRECTOR, OFFICE OF INVESTIGATIONS, REGION II~~