Florida Power & Light Company, 6501 S. Ocean Drive, Jensen Beach, FL 34957

November 21, 2007

L-2007-181
10 CFR 2.201

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

Re: St. Lucie Units 1 and 2
Docket Nos. 50-335 and 50-389
Reply to a Notice of Violation; EA-70-170

Florida Power & Light Company (FPL), the licensee for the St. Lucie Nuclear Plant, hereby submits the following reply to Notice of Violation EA-70-170.

Please contact us if there any questions on this information.

Very truly yours,

Gordon L. Johnston
Site Vice President
St. Lucie Plant

GLJ/KWF

cc: NRC Region II Administrator
St. Lucie NRC Resident Inspectors

IE01
NRR

Violation:

During an NRC investigation completed on April 17, 2007, a violation of NRC requirements was identified. In accordance with the Enforcement Policy, the violation is listed below:

10 CFR 50.9(a) states, in part, that information provided to the Commission by a licensee or information required by the Commissions regulations, orders or license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

St. Lucie Technical Specifications, Section 6.8.1(a), states, in part, that written procedures shall be established, implemented and maintained covering the applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2, February 1978.

Administrative Procedure, ADM-0010432, Control of Plant Work Orders, provides the requirements and controls for initiating, approving, authorizing, and implementing Work Orders (WOs) for work activities on Safety Related (SR), Quality Related (QR) and Power Block systems, components, structures and equipment described in the Safety Analysis Report (SAR).

Work Order (WO) 35002193-01 was generated as QR to replace the valve diaphragm on valve 6184 because it showed signs of leaking. The WO instructions were to replace the diaphragm in accordance with a safety-related Mechanical Maintenance Procedure, 0-MMP-80.27.

0-MMP-80.27, Grinnel Handwheel Operated (3 Inch and Under) Diaphragm Valves, step 6.6.18 requires that the bonnet nuts be tightened in the final torque specified in Table 1 of the same procedure. Table 1 also referenced the torque value required to be used and specified that maintenance conducted on a 2-inch valve should be 96 in-lbs or 8 ft-lbs.

Contrary to the above, on March 10, 2005, the licensee violated 10 CFR 50.9(a). When performing maintenance on St. Lucie Unit 1 Valve 6184, an isolation valve in the suction line of radwaste holdup drain pump 1B, on March 10, 2005, two contract valve technicians used a wrench to torque the valve which was not specified by 0-MMP-80.27, contrary to plant Technical Specification 6.8.1 and plant procedures. As a result, the two technicians applied a wrong torque value of 20[1] ft-lbs to the valve, instead of the required 8 ft-lbs. The technicians checked out the correct torque wrench after the incident for a few minutes, but did not use it. They then entered information on WO 35002193-01 indicating that the correct wrench had been used. The inaccurate information was material to the NRC because it concealed the overtorquing of the valve.

1 The actual value applied was 19.2 ft-lbs.

FPL response:

a) The reason for the violation, or, if contested, the basis for disputing the violation or severity level.

FPL concurs that the cited violation occurred as stated in the Notice of Violation. The violation occurred as a result of intentional actions by two contract employees. The contract technicians deliberately failed to adhere to plant Technical Specifications and plant procedures. Specifically, on March 10, 2005, the contract technicians used an incorrectly sized torque wrench in violation of the requirements of the WO for Valve 6184. Upon realization of their error, the contract technicians falsified the WO documentation for the work to indicate that the correct torque wrench had been used. The contract technicians' actions were in direct contravention of FPL policy and procedure.

b) The corrective steps that have been taken and the results achieved.

1. On March 10, 2005, upon notification that the proper torque wrench may not have been used, FPL supervision directed a different crew to disassemble, inspect, and reassemble the valve bonnet for Valve 6184. The rework was documented in the journeyman's work report for WO 35002193-01.

2. A St. Lucie Lessons-Learned Bulletin was deployed for all Corrective Action Program Coordinators (CAPCOs) on October 26, 2006 to ensure that identified condition reports (CRs) contain sufficient detail for the Condition Report Owner's Group (CROG) to make informed decisions regarding level, investigation type, and immediate action recommendations.

3. The initial CR was evaluated by an individual who had no personal knowledge of the event or its resolution. The details of actions taken against the contract technicians were not provided to the CR evaluator during his interviews with knowledgeable personnel, and a sufficient questioning attitude was not demonstrated by the evaluator. In order to prevent recurrence, the Corrective Action Program expectations handbook was revised to provide guidance in a situation where the CR evaluator is not the person primarily responsible for the event/issue. The revised handbook requires the system / process owner to agree with the evaluator's analysis and sign the evaluation. This policy makes the most responsible and knowledge personnel ultimately accountable for the resolution of an issue.

4. To properly document the extent of condition, FPL Mechanical Maintenance and the Nuclear Components and Replacement (NCAR) department reviewed all of the work performed in support of the St. Lucie maintenance department and NCAR, respectively, by the two contract technicians involved in the originating event from the SL2-15 outage to the present. This action was completed on November 12, 2006.

c) The corrective steps that will be taken to avoid further violations

All corrective actions to avoid further violations are complete and are described above.

d) The date when full compliance will be achieved.

Full compliance with 10 CFR 50.9(a) was achieved on March 10, 2005, when WO 35002193-01 was revised to reflect the rework performed on the valve.