



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

December 16, 2008

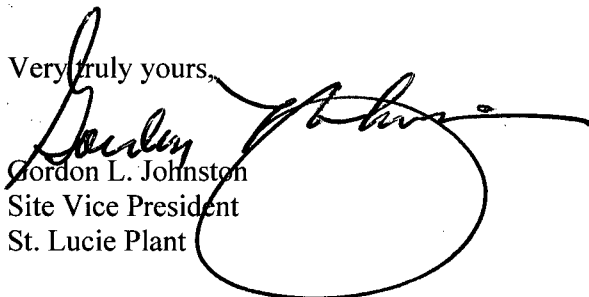
L-2008-259  
10 CFR 73.71

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

Re: St. Lucie Unit 1 and 2  
Docket No. 50-335  
Reportable Event: 2008-001  
Date of Event: October 18, 2008  
Unattended Ammunition Discovered Inside Protected Area.

The attached Licensee Event Report 2008-001 is being submitted pursuant to the requirements of 10 CFR 73.71 Appendix G to provide notification of the subject event.

Very truly yours,

  
Gordon L. Johnston  
Site Vice President  
St. Lucie Plant

GLJ/dlc

Attachment

IE74  
MRB

**LICENSEE EVENT REPORT (LER)**

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

<b>1. FACILITY NAME</b> St. Lucie Units 1 and 2	<b>2. DOCKET NUMBER</b> 05000335	<b>3. PAGE</b> 1 of 3
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**4. TITLE**  
Unattended Ammunition Discovered Inside Protected Area

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
10	18	2008	2008	- 001	- 00	12	16	2008	FACILITY NAME	DOCKET NUMBER

<b>9. OPERATING MODE</b> 1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: (Check all that apply)									
<b>10. POWER LEVEL</b> 100%	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)						
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)						
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input checked="" type="checkbox"/> OTHER							
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A							

**12. LICENSEE CONTACT FOR THIS LER**

NAME Donald L. Cecchett - Licensing Engineer	TELEPHONE NUMBER (Include Area Code) 772-467-7155
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**13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT**

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
A	N/A	N/A	N/A	NO					

<b>14. SUPPLEMENTAL REPORT EXPECTED</b> <input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	<b>15. EXPECTED SUBMISSION DATE</b>	MONTH . DAY . YEAR
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**ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)**

On October 18, 2008, St. Lucie Units 1 and 2 were operating normally in Mode 1 at 100% power when a box containing six ammunition cans was discovered inside a warehouse within the protected area. The box containing the ammunition was received and searched on October 6, 2008, but contents of the box were not identified as ammunition before being processed into the protected area. The event was reported to the NRC in accordance 10 CFR 73.71 Appendix G.

The Root Cause Evaluation identified that a latent organization weakness resulted in an ineffective search by Security and a failure to implement process controls during identification and authorization of materials before entry into the protected area (PA).

Corrective actions included procedure revisions, training, establishment of a segregated area outside of the protected area for materials not authorized for entry into the protected area, alignment of plant procedures to Physical Security Plan, and effectiveness measures to evaluate security search performance.

**LICENSEE EVENT REPORT (LER)**  
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St. Lucie Units 1 and 2	05000335	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	Page 2 of 3
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**NARRATIVE**

**Description of the Event**

On October 18, 2008, at the St. Lucie Material's Warehouse a sealed cardboard box containing six cans of ammunition was discovered unattended inside the Protected Area (PA). The container was previously received and searched via x-ray on October 6, 2008, but its contents were not identified. The event was reported to the NRC in accordance 10 CFR 73.71 Appendix G.

**Cause of the Event**

An evaluation of the event identified that a latent organization weakness resulted in an ineffective search by Security and a failure to implement process controls during identification and authorization of materials, before entry into the protected area (PA).

**Analysis of the Event**

A review of the event determined the contents of the box were not positively identified by Security when using the X-Ray machine. Additionally, contributing causes included multi-tasking which contributed to the lack of Security Officer focus to x-ray duties and volume of materials being scanned and poor alignment (inconsistencies) between plant procedures and Physical Security Plan.

Other contributing causes to the improper search included: lack of verification and authorization of the box prior to entry into the PA: lack of written instruction regarding handling/processing of ammunition: and exclusive reliance upon X-ray searches for identification of contents. As a result, a box containing ammunition was not identified as containing ammunition and was permitted to enter the PA before being properly processed. This event resulted in a one hour reportable event to the NRC per 10CFR 73.71 Appendix G was made.

**Analysis of Safety Significance**

Given that the location of the uncontrolled box of ammunition was unknown until discovered within the warehouse by a Nuclear Material's Management employee; there is no safety related equipment in the warehouse area or in close proximity; and there are no firearms at PSL that are capable of firing the caliber of ammunition found, it is concluded there was no threat to the health and safety of the general public or risk of radiological sabotage.

**Corrective Actions**

The corrective actions and supporting actions have been entered into the site corrective action program. Any changes to the proposed actions will be managed under the corrective action program.

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**NARRATIVE**

Immediate Corrective Actions

1. Site wide extent of condition walk downs were conducted in locations where packaged materials are located to identify potentially unsearched packages.
2. Communications were conducted to provide new instructions on the package search and material hand search processes used at the warehouse loading dock to ensure that searched loading dock material remains separated from unsearched material.
3. Communications were conducted to provide confirmation that all packages have been verified and authorized prior to allowing materials "On-Site."
4. Established a Supervisor Post to oversee the vehicle and packaged material search process.

Corrective Actions:

1. Revise Security procedures to include additional requirements regarding specific roles and responsibilities of Security personnel involved in the material search process.
2. Established a Supervisor Post to oversee the vehicle and packaged material search process.
3. Revise Warehouse Receipt, Storage, Issuance and Maintenance procedures for receiving, handling and storing of items procured without category identification (Non PO Material) and not processed by the Nuclear Supply Chain.
4. Conduct effectiveness measures to evaluate security search performance.

**Similar Events**

A search of the corrective action database for St. Lucie was performed to identify events related for the past 3 years determined there were no documented cases of unauthorized material entering the protected area.

**Failed Components**

N/A