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 50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co. 05000389

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 RECIP. NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Responds to violations noted in insp repts 50-335/95-01 & 50-389/95-01. Corrective actions: chemistry dept enhanced computer program for logging sample results to include time dependent notification sys for tracking requests.

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L-95-092
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 Notice of Violation
Inspection Report 95-01

Florida Power and Light Company (FPL) has reviewed the subject inspection report and pursuant to 10 CFR 2.201 the response to the notice of violation is attached.

Very truly yours,

A handwritten signature in cursive script that reads 'J. H. Goldberg'.

J. H. Goldberg
President - Nuclear Division

JHG/DAS/JWH

Attachment

cc: Stewart D. Ebnetter, Regional Administrator, USNRC Region II
Senior Resident Inspector, USNRC, St. Lucie Plant

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VIOLATION A:

Technical Specification surveillance requirement 4.5.1.1.b required, in part, that safety injection tanks be demonstrated operable within six hours of each solution volume increase of greater than or equal to one percent of tank volume by verifying the boron concentration of the safety injection tank solution.

Contrary to the above, on December 31, 1994, a volume addition in excess of one percent was made to the 1A2 safety injection tank without verifying the boron concentration of the resultant solution within six hours. A satisfactory sample result was obtained approximately nine hours later.

RESPONSE A:

1. REASON FOR VIOLATION

The root cause of this event was that the Chemistry technician sampled the 1A1 Safety Injection Tank (SIT) in error after a volume addition to the 1A2 tank. Additionally, procedures used for tracking event driven surveillances to completion were found to be inadequate. In analyzing this specific event, an independent review of surveillances missed during the past five years was conducted. The results of this analysis revealed a process weakness in tracking event driven surveillances.

2. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

- A. Operations personnel identified the error during a review of the control room chronological log and contacted Chemistry to sample the correct (1A2) SIT.
- B. Chemistry technicians sampled the 1A2 Safety Injection Tank which yielded satisfactory results.

3. CORRECTIVE STEP TO AVOID FURTHER VIOLATIONS

- A. The Operations Department revised OP 1-0410021 and OP 2-0410021 "Safety Injection Tank Normal Operating Procedures", to include a data sheet for tracking and verification of SIT boron samples. This data sheet will remain with the shift Reactor Operators from the time a SIT is filled until the results from Chemistry are satisfactorily obtained.

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- B. The Chemistry Department has enhanced their computer program for logging sample results to include a time dependent notification system for tracking sample requests.
- C. A technical subcommittee reviewed and analyzed this specific event including the generic implications. Their findings concluded that the plant's methods for conducting scheduled surveillances ensured proper execution, however for surveillances that were event driven, insufficient controls existed to track completion. The following corrective actions resulted from the subcommittee's review:
1. Operations Department has revised AP 1-0010125A and AP 2-0010125A, "Surveillance Data Sheets" to include a separate data sheet that tracks event driven TS surveillances to completion.
 2. The plant Licensing Department and Technical Department will review both units' Technical Specifications to ensure all event driven surveillances have implementing procedures. This action will be completed by July 30, 1995.
4. Full compliance was achieved on December 31, 1994 with the completion of item 2.B. above.

VIOLATION B:

Technical Specification (TS) 6.8.1.a required that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Appendix A, paragraph 1.d includes administrative procedures for procedure adherence. Appendix A, paragraph 9 includes procedures for performing maintenance.

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Procedure QI 5-PR/PSL-1, Revision 60, "Preparation, Revision, Review/Approval of Procedures," Section 5.13.2 stated that all procedures shall be strictly adhered to. Letter of Instruction 2-LOI-T-89, Revision 0, "Diagnostic Testing of Letdown Level Control System," required that the positive and negative leads to E/P 2110Q be reconnected and independently verified prior to placing valve LCV-2110Q in service for diagnostic testing.

Contrary to the above, on February 1, 1995 procedure 2-LOI-T-89 was not properly implemented in that the positive and negative leads to E/P 2110Q were not properly reconnected or Independently Verified due to the leads being reversed, resulting in valve LCV-2110Q not opening when it was placed in service. This failure resulted in a loss of letdown flow and required that charging be secured until the redundant level control valve could be placed in service.

RESPONSE B:

1. REASON FOR VIOLATION

The root cause of this event was personnel error by an Instrument and Control (I&C) Specialist in failing to adequately apply self-checking principles. In addition, there was a personnel error on the part of an I&C supervisor to perform a proper Independent Verification.

2. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

The electrical leads for the letdown valve were properly relanded and independently verified on February 1, 1995. The valve was then placed back in service and operated properly.

3. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A. The individuals involved in this event were counselled, and discipline was administered in accordance with company policy.



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- B. The plant Technical Department is developing a new Administrative Procedure which more clearly defines and consolidates the Independent Verification process for all departments. This procedure will be implemented by April 28, 1995.
 - C. This event and the requirements for Independent Verification as delineated in the new administrative procedure will be incorporated into training. This will be incorporated by June 30, 1995.
 - D. Self-Checking principles will be incorporated into the On the Job Training/Task Performance Evaluation portion of the Maintenance Continued Training Program. This will be incorporated by June 30, 1995.
4. Full compliance was achieved on February 1, 1995 with the completion of item 2 above.