

CATEGORY 1

REGULATOR INFORMATION DISTRIBUTION SYSTEM (RIDS)

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 GOLDBERG, J.H. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Forwards response to violations noted in insp repts
 50-335/95-17 & 50-389/95-17. Corrective actions: I&C maint
 personnel performed dedication testing on remaining diodes
 of same stock code which had not been installed.

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L-96-22
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 95-17

Florida Power and Light Company 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/EJB

Attachment

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

060065

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PDR ADOCK 05000335
Q PDR

Handwritten initials, possibly "JEB", with a vertical line below them.

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VIOLATION:

10 CFR 50 Appendix B, Criterion V, Instructions, Procedures, and Drawings, as implemented by FPL Topical Quality Assurance Report (FPLTQAR 1-76A), requires that activities affecting quality shall be prescribed by documented procedures and activities shall be accomplished in accordance with these procedures.

Contrary to the above, on December 4-15, 1995, three examples were identified in which activities affecting quality were not accomplished in accordance with prescribed procedures or instructions.

Example 1:

Procedures AP 0010432, Nuclear Plant Work Orders, revision 87, and QI7-PR/PSL-1, Control of Purchased Material, Equipment and Services, revision 28, require that material field dedication be performed as specified on material identification tags and related procurement evaluations. Work Orders 95020550, 95020551, 95020552, and 95020545, dated November 27, 1995, installed unqualified diodes on safety related Reactor Coolant System (RCS) Vent System solenoid valves V-1460, V-1461, V-1462, and V-1463. The commercial grade dedication testing specified on the material identification tags and specified on procurement evaluation 039431 was not performed.

Example 2:

Procedure IP-1102, In-Storage Maintenance and Shelf Life Program, revision 0, requires that equipment in-storage maintenance and shelf life requirements be entered into the shelf life program. Purchase orders 0007466 and 0007379, dated October and December, 1994, received regulated power source devices. The commercial grade dedication evaluation 036828 included a requirement to energize the devices every two years to maintain the shelf life. As of December 5, 1995, this requirement was not entered into the shelf life maintenance program.

Example 3:

FPL Supplier Deviation Notice SDN-SL-95-034-5 dated November 21, 1995, identified that the fuses procured on Purchase Order 00012173 did not meet FPL test requirements. Engineering evaluation 040129 provided instructions for resolution of the SDN which required the unqualified fuses be placed on hold for additional engineering evaluation upon receipt from the vendor. The fuses were subsequently receipt inspected and made available for safety related issue in the warehouse without the specified engineering evaluation.

FPL RESPONSE:

1. CONCURRENCE AND REASON FOR THE VIOLATION

FPL concurs with the above violation.

1. Reason for Example 1 of the violation:

The root cause for the failure to perform the required dedication testing on diodes described in Example 1 was cognitive personnel error by contractor personnel. The diodes were labelled with material identification tags which identified the components as parts requiring additional dedication testing. The contractor personnel who received the diodes from the material warehouse did not understand the meaning of the identification tags which accompanied the materials and incorrectly assumed that all required testing had been completed.

A contributing factor in this event was that the level of detail included in the initial training of the contractor personnel involved in this event was insufficient to fully address the administrative requirements related to material dedication.

2. Reason for Example 2 of the violation:

The root cause for the failure to include shelf life requirements described in Example 2 was an inadequate inter-departmental process for transmitting, and verifying the receipt of, in-stock dispositions. The process did not require confirmation that the in-stock disposition had been received and that the appropriate actions had been implemented. As a result, the requirement to enter the subject power source devices into the shelf life program, as required by the engineering evaluation and approved plant procedure, was not implemented.

3. Reason for Example 3 of the violation:

The immediate cause for the failure to comply with the requirements of the engineering "hold" cited in Example 3, was a software programming deficiency which effectively allowed data concerning the engineering evaluation to go unidentified. FPL uses an electronic database program to identify engineering holds by use of a computer message, or "flag".

The root cause for this event was that the software testing process used in this application was insufficient to identify an error with this particular program feature. A review of the software testing methodology showed that the specific testing performed would not have exposed the type of error which occurred in this case.

2. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

1. Corrective steps taken for Example 1:

- a. FPL Instrument and Control maintenance personnel performed dedication testing on the remaining diodes of the same stock code which had not been installed in the plant, in accordance with procurement evaluation 039431. Operability of the installed diodes was then established based on satisfactory completion of the dedication testing performed on the diodes in stores, and the post modification valve testing performed following the installation of the subject diodes into the RCS solenoid valves. All testing was completed in accordance with engineering disposition to St. Lucie Action Report (STAR) 952133, on December 13, 1995.
- b. The contractor personnel involved in this event, their supervisors, and other contractor personnel required to receive materials from stores for installation in the plant, were given additional training. This training emphasized the lessons learned from this event and reviewed the administrative requirements associated with material dedication. This action was completed on January 18, 1996, per STAR 960081A.

2. Corrective steps taken for Example 2:

- a. The subject power source devices were entered into the shelf life program as required by the commercial grade procurement evaluation and FPL procedure. This action was complete on December 12, 1995.
- b. A self-assessment to validate current inventory by means of physical comparison to the material catalog description for all Procurement Classification (PC)-1, 2 and 3 material was conducted from September 1, 1995, until December

22, 1995. The validation self-assessment included a review of shelf life requirements. The self-assessment identified 75 shelf life discrepancies out of more than 19,000 stock codes reviewed. The discrepancies were corrected by either in-stock replenishment, database correction, or engineering-approved shelf life extensions. The shelf life discrepancies identified by the self-assessment were corrected by December 22, 1995.

3. Corrective steps taken for Example 3:
 - a. The subject fuses were placed on hold by Procurement Engineering pending additional evaluation. In addition, plant staff verified that none of the subject fuses had been used in safety-related applications.
 - b. FPL performed an investigation of the generic implications resulting from the programming error. Potential problems were reviewed at both St. Lucie and Turkey Point sites. No additional material deficiencies were identified as a result of this review.
 - c. Nuclear Information Services (NIS) issued a software correction to the affected plant database program on December 8, 1995, per STAR 952127.

3. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

1. Corrective steps to avoid further violations as identified in Example 1:
 - a. A comprehensive review of the programmatic controls associated with dedication testing, to include work instructions, training, and administrative controls, will be conducted to determine where additional improvements can be made in this area. This action will be completed by April 30, 1996.
 - b. The material tags used to identify components which require additional testing prior to use in the plant will be revised to improve administrative control. As part of this action, FPL will review industry best practice in this area. This action will be complete by March 29, 1996.

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- c. The program for initial orientation and continuing contractor training will be modified to include coverage of appropriate St. Lucie and industry operating experience. This action will be completed by April 30, 1996.
 2. Corrective steps to avoid further violations as identified in Example 2:
 - a. The process for implementing shelf life requirements has been changed to eliminate the need for a manual transfer of information. FPL Nuclear Materials Management (NMM) is now using a common database system with Procurement Engineering which has improved the interface process between the two organizations. Use of a common database system provides a feedback process for verification of in-stock dispositions.
 - b. FPL will assess the overall process for identifying and implementing material shelf life requirements to determine where additional improvements can be made. This assessment will include a review of industry best practice in this area. This action will be complete by April 30, 1996.
 - c. NMM is currently performing additional materials verification to confirm that all actions required as a result of previous in-stock dispositions have been completed. This verification will be complete by April 30, 1996.
 3. Corrective steps to avoid further violations as identified in Example 3:
 - a. This event and its corrective actions were reviewed with the analysts and programmers associated with the subject database system. Additional training, which reviewed current testing requirements, was conducted for NIS personnel on January 12, 1996.
 - b. NIS will incorporate into the Software Quality Assurance program the additional requirement to identify and appropriately test any "critical functionality" associated with a software application being developed. Critical functionality refers to those attributes of a software application whose failure may not be readily detectable or obvious, and could result in



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quality being adversely affected. This action will be complete by February 29, 1996.

- c. A special training session will be conducted to review critical functionality identification and testing requirements for appropriate NIS personnel. This action will be complete by February 29, 1996.
4. Full compliance was achieved by January 18, 1995, with the completion of items 2.1 through 2.3 above.