CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9606030157 DOC.DATE: 96/05/28 NOTARIZED: NO DOCKET #
FACIL:50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co. 05000335
AUTH.NAME AUTHOR AFFILIATION
PLUNKETT,T.F. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Responds to violations noted in insp rept 50-335/96-04. Placed experienced ex-operators on shift throughout remainder of current outage & power ascension,augmented QA organization & added addl mgt review of control room logs.

DISTRIBUTION CODE: IE01D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 14
TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD2-3 PD	1	1	WIENS,L.	1	1
INTERNAL:	ACRS	2	2	AEOD/SPD/RAB	1	1
	AEOD/TTC	1	1	DEDRO	1	1
	FILE CENTER	1	1	NRR/DISP/PIPB	1	1
	NRR/DRCH/HHFB	1	1	NRR/DRPM/PECB	1	1
	NRR/DRPM/PERB	1	1	NUDOCS-ABSTRACT	1	1
	OE DIR	1	1	OGC/HDS3	1	1
	RGN2 FILE 01	1	1			
EXTERNAL:	LITCO BRYCE,J H	1	1	NOAC	1	1
	NRC PDR	1	1			

NOTE TO ALL "RIDS" RECIPIENTS:
PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK, ROOM OWFN 5D-5(EXT. 415-2083) TO ELIMINATE YOUR NAME FROM DISTRIBUTION LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 19 ENCL 19

CATEGORY 1 DOCUMENT

Florida Power & Light Company, P.O. Box 14000, Juno Beach, FL 33408-0420

FPL

MAY 28 1996

L-96-132
10 CFR 2.201

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

Re: St. Lucie Unit 1
Docket No. 50-335
Reply to Notice of Violation
Inspection Report 96-04

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.

We have carefully reviewed NRC integrated Inspection Report 50-335/96-04, especially focusing on the comments and observations in the forwarding letter and share your concern about personnel performance in the areas of procedural compliance and usage, and attention to detail. Actions have been taken, and are continuing, to address personnel performance. We are also addressing previous shortcomings in leadership and management at St. Lucie Plant to assure ourselves, and the NRC, that we are committed to improving the plant's performance in all areas. An important aspect of these leadership improvements is holding all plant personnel accountable and responsible for their actions. A lack of personnel accountability and responsibility are key ingredients in the four violations cited in the inspection report.

With regard to the violations involving inappropriate actions by operators in the field (i.e., Violations A and C of the attached), we are emphasizing the need for higher standards of conduct and are increasing oversight of Operations' activities. Specifically, we have placed experienced ex-operators from our Juno Beach corporate office and from Turkey Point on shift throughout the remainder of the current outage and power ascension. Also, we have augmented our Quality Assurance organization at St. Lucie Plant and have added additional management review of control room logs to reinforce expectations of logtaking standards.

030003

The programmatic concerns you articulated in the inspection report's cover letter will be discussed further at the June 12, 1996, NRC/FPL meeting at the plant.

Very truly yours,

T. F. Plunkett
President
Nuclear Division

TFP/JAS/EJB

Attachment

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

St. Lucie Unit 1
Docket No. 50-335
Reply to Notice of Violation
Inspection Report 96-04

VIOLATION A:

Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2, February, 1978. Appendix A, paragraph 1.d includes administrative procedures for procedural adherence. QI 5-PR/PSL-1, Rev 68, "Preparation, Revision, Review/Approval of Procedures," Section 5.13.1, states that all procedures shall be strictly adhered to.

Step 7.5.1.R of procedure HPP-22, Rev 2, "Air Sampling," required that valve 3 of the Unit 1 containment Particulate Iodine Gaseous Monitor be returned to the open position following the performance of a containment grab sample.

AP 0010120, Rev 79, "Conduct of Operations, Appendix F, "Log Keeping," required, in part, that "Log readings shall be compared to previous readings to detect abnormal trends or conditions and verified to be within the minimum and maximum values for that parameter. All log readings outside the min/max values shall be circled with reasons stated for abnormal readings (i.e., OOS, NPWO, ISOL, etc)."

Contrary to the above:

1. On February 22, 1996, a health physics technician performing a grab sample of the Unit 1 containment failed to return valve 3 to the open position and, as a result, rendered the monitor inoperable.

2. On February 22, 23, and 24, 1996, Senior Nuclear Plant Operators failed to perform adequate reviews of logs taken in the Unit 1 Reactor Auxiliary Building, as the out-of-specification log readings taken on the Unit 1 containment particulate iodine gaseous monitor were not highlighted and explained. As a result, the Unit 1 containment Particulate Iodine Gaseous monitor remained inoperable and Unit 1 transitioned from Mode 3 to Mode 2 without satisfying Technical Specification Limiting Condition for Operation 3.4.6.1. The Mode transition was prohibited by Technical Specification 3.0.4.

RESPONSE A:

1. FPL concurs with the violation.

2. REASON FOR VIOLATION

The cause of the violation was cognitive personnel error by a utility non-licensed health physics (HP) technician who failed to obtain and follow an approved plant procedure which addressed the positioning and realignment of valves during containment atmosphere sampling.

Several additional factors contributed to this event:

1) The absence of sign off requirements in the procedure contributed to the performance of the evolution without the approved procedure in hand.

2) An inadequate review of operator log readings by licensed and non-licensed operations personnel contributed to a delay in identifying that the sample flow to the monitor had been isolated.

3) The flow fault indicator switch for the containment atmosphere process monitor did not alarm in the control room when sample flow was reduced below an operable level.

4) Operations personnel did not routinely declare the containment Particulate Iodine Gaseous monitor out of service when grab samples were being taken.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

At approximately 1210 on February 24, 1996 valve number 3 for the containment Particulate Iodine Gaseous monitor was reopened which restored sample flow and returned the monitor to service.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A) The health physics procedure for obtaining containment atmosphere samples, HPP-22, was revised to require prior notification to the control room and signatures for all valve manipulations when obtaining containment grab samples. Additionally, the procedure was changed to require that the St. Lucie Units 1 and 2 containment Particulate Iodine Gaseous monitors be declared out of service when grab samples are being taken which require sample flow to be diverted.

B) The Conduct of Operations Procedure, AP 0010120, was changed to require that an explanation be documented for log entries which are found to be outside of the minimum or maximum acceptance values defined on the operator log sheets.

C) FPL is determining the appropriate set point range for the containment Particulate Iodine Gaseous monitor low flow switch. When this action is complete, procedures will be revised as necessary to include a calibration and functional test of this flow switch. This action will be completed by August 31, 1996.

D) This event was reviewed with St. Lucie health physics technicians to re-emphasize the need for strict procedural adherence. Additionally, the Operations Manager issued a memo to all operations personnel, including Health Physics and Chemistry Departments, which discussed this event and outlined immediate changes in operating practices that were to be followed in order to ensure that events of this nature are not repeated.

E) A night order was issued to reinforce the requirement that equipment whose operability is affected by surveillance testing or maintenance be declared inoperable during the performance of the test or maintenance.

F) Operations supervision will perform a review of non-licensed operator log sheets from May 1, 1995, to April 1, 1996, to affirm that no additional components have been inadvertently rendered inoperable or otherwise overlooked. This will be completed by July 31, 1996.

G) Health physics guidance and the HP procedures used to implement Technical Specification requirements were reviewed for adequacy and operational impact. No other component operability concerns were identified during the review.

H) Chemistry procedures will be reviewed for their impact to operations and revised as necessary to ensure that administrative controls are adequate for any evolutions which could potentially affect equipment operability. This action will be completed by June 30, 1996.

I) The health physics technician and operations personnel involved in this event were disciplined in accordance with plant policy.

5. Full compliance was achieved on February 24, 1996, with the completion of item 3 above.

6. Additional Information

This violation has also resulted in FPL taking actions to instill a greater level of responsibility and accountability in St. Lucie Plant personnel, especially focusing on non-licensed operator performance. The actions FPL has taken, or will take, include the following:

A) On April 1, 1996, St. Lucie Plant implemented a problem reporting process, called "Condition Reports," which is similar to the problem reporting process in use at Turkey Point Units 3 and 4. Condition Reports are to be used by all plant personnel to identify plant nonconformances, events, or conditions that may be adverse to the safe and orderly conduct of plant operations. Specific events to be reported via Condition Reports include exceeding Technical Specification Limiting Conditions for Operation. The use of Condition Reports as a means of identifying issues which need to be addressed and rectified has become widely accepted at St. Lucie Plant. The level of responsibility and accountability for identifying discrepant conditions by St. Lucie Plant personnel will continue to improve as a result of the new Condition Report process.

There have been several recent instances in which Condition Reports have been used by plant personnel to identify discrepant conditions indicating a trend towards increased responsibility and accountability in site personnel. These instances include reporting foreign material exclusion concerns, the potential for missed Technical Specification Surveillances, potential plant systems' operability concerns, and procedural weaknesses.

Human performance evaluations are performed on events identified in Condition Reports which have the potential to be related to personnel performance, poor procedural guidance, or man-machine interaction concerns. Corrective actions identified by the human performance evaluations are included in Condition Report corrective actions and are tracked to completion within the Plant Management Action Item system.

B) Since the violations discussed in Inspection Report 96-04 occurred, FPL has assigned the Operations Manager from Turkey Point Units 3 and 4 to assist the St. Lucie Plant. This individual has been personally responsible for

instituting many of the operational improvements at Turkey Point over the last several years. He is conducting crew briefings with licensed and non-licensed personnel to make known his expectations for accountability and responsibility as well as to emphasize to Operations Department personnel that they will be held accountable and responsible for their decisions and actions.

C) On May 6, 1996, FPL started a campaign of increased oversight of operational activities, plant personnel performance, and plant conditions. Senior members of the FPL staff with operations experience, and not assigned permanently to St. Lucie Plant, have been placed on-shift, around the clock, to monitor the conduct of operations through the Unit 1 refueling outage and power ascension. The on-shift oversight roles are providing FPL with feedback on areas to improve Operations Department performance.

D) On May 6, 1996, FPL also temporarily assigned additional quality assurance (QA) personnel from Turkey Point Plant and the FPL Nuclear Division corporate office in Juno Beach to St. Lucie Plant to conduct auditing and oversight of all areas of plant activity. The additional QA presence is intended to identify areas in which added responsibility, accountability, and plant process controls are needed.

E) Chemistry and Health Physics are the only plant departments which operate valves and controls within their departmental scope without control room knowledge or permission (see Corrective Actions 4.G and 4.H, above). Other routine and non-routine evolutions which may render components inoperable are performed under a Plant Work Order (PWO) with control room cognizance and permission. By memorandum dated May 22, 1996, the Maintenance Manager reinforced to Maintenance Department personnel their procedural compliance responsibilities and the potential impacts of maintenance on plant operation.

F) Management is already re-emphasizing the importance of the operator's role in providing early detection of off-normal plant conditions during logtaking and log review. To ensure closer communications between operations shift personnel and plant management, St. Lucie Plant is instituting periodic meetings with operations personnel, both licensed and non-licensed, while in the requalification training cycle. These meetings will provide a forum for feedback and discussion on

expectations, concerns, and problems encountered day-to-day in plant operations. Plant management will discuss face to face with the operators their expectations regarding operator performance, accountability, and degree of responsibility. These meetings will begin at the start of the post-Unit 1 outage requalification training.

G) To ensure that non-licensed operators are aware of how their actions affect the plant's operation and Technical Specification requirements, FPL will focus non-licensed operators' training on understanding operability requirements for safety and non-safety related systems in various modes of plant operation. This training will aid in the early detection of off-normal conditions during logtaking and log review through a questioning attitude. As the non-licensed operators gain an improved understanding, they can better assess the logic and impact of their field actions. This training will begin in the upcoming requalification training cycle 96-04.

VIOLATION B:

Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2, February, 1978. Appendix A, paragraph 1.d includes administrative procedures for procedural adherence. QI 5-PR/PSL-1, Rev 68, "Preparation, Revision, Review/Approval of Procedures," Section 5.13.1, states that all procedures shall be strictly adhered to.

AP 0010120, Rev 80, "Conduct of Operations," Appendix F, "Log Keeping," required, in part, that reactivity manipulations be entered in the Reactor Controls Operator Chronological Log.

AP 0010120, Rev 80, "Conduct of Operations," Appendix F, "Log Keeping," required, in part, that abnormal conditions in turbine-generator auxiliary systems be entered in the Reactor Controls Operator Chronological Log.

Contrary to the above:

1. On March 27, 1996, St. Lucie Unit 1 operators performed two Reactor Coolant System dilutions (reactivity manipulations), which were not entered in the Reactor Controls Operator Chronological Log.

2. On March 27, 1996, hydrogen was added to restore a low pressure condition in the St. Lucie Unit 1 generator and

was not entered in the Reactor Controls Operator Chronological Log.

RESPONSE B:

1. FPL concurs with the violation.

2. REASON FOR VIOLATION

The cause of this event was the failure of licensed control room operators to consistently apply the administrative guidance which existed regarding the requirements for control room chronological log entries. The instructions contained within the Conduct of Operations Procedure, AP-0010120, were not consistently applied by the operating crews due to differing interpretations between control room licensed operators and operations management.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

A) The Operations Supervisor issued a night order on March 28, 1996, to clarify the expectations for chronological log entries with regard to reactivity manipulations and the addition of hydrogen to the main generator.

B) A revision was made to the Boron Concentration Control procedures, OP 1/2-0250020, which established a separate logsheet to facilitate and improve the tracking of borations and dilutions to the reactor coolant system. This revision was issued on April 26, 1996.

C) The Conduct of Operations Procedure, AP-0010120, was reviewed and log keeping requirements were revised to clarify management expectations. This revision was issued on April 26, 1996.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A) The Reactor Control Operator (RCO) chronological log was reviewed following this event by the Operations Supervisor to verify that subsequent reactivity manipulations and additions of hydrogen to the main generator were being properly logged. This review was completed on May 14, 1996.

B) The Operations Manager issued a memo to all department members which emphasized his expectation that personnel are to remain cognizant of procedural requirements and

that log entries at all watchstations are to be performed in accordance with established procedural guidance.

5. Full compliance was achieved on April 26, 1996, with the completion of items 3A, 3B and 3C above.

VIOLATION C:

Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2, February, 1978. Appendix A, paragraph 1.d includes administrative procedures for procedural adherence. QI 5-PR/PSL-1, Rev 68, "Preparation, Revision, Review/Approval of Procedures," Section 5.13.1, states that all procedures shall be strictly adhered to.

OP 1-2200050A, Rev 24, "1A Emergency Diesel Generator Periodic Test and General Operating Instructions," Appendix E required, in part, that the 1A Emergency Diesel Generator Fuel Oil Storage Tank be recirculated by establishing a flow path from the tank, through the transfer pump, and through valves V17207 and V17208 back to the tank.

QI 1-PR/PSL-2 , Rev 26, "Operations Organization," and AP 0010120, Rev 79, "Conduct of Operations," Appendix A, required that Senior Nuclear Plant Operators "..:report promptly to the Control Room any equipment or valve manipulations so that the RCO will be aware of the current plant status."

Contrary to the above:

1. On January 5, a Senior Nuclear Plant Operator placed the 1A Emergency Diesel Generator Fuel Oil Storage Tank in recirculation by isolating the discharge of the transfer pump and allowing the fuel to be recirculated back to the tank via the pump's minimum flow line. The isolation of the transfer pump's discharge resulted in the Emergency Diesel Generator being inoperable.

2. On January 5, a Senior Plant Nuclear Operator failed to notify the Unit 1 control room of a valve manipulation made to place the 1A Emergency Diesel Generator on recirculation.

RESPONSE C:

1. FPL concurs with the violation.

2. REASON FOR VIOLATION

The cause of the violation was cognitive personnel error by a utility non-licensed operator who failed to obtain and follow an approved plant procedure for placing the diesel fuel oil storage tank on recirculation. Additionally, the operator failed to properly notify the control room of his actions.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

On January 5, 1996, at approximately 0245, Unit 1 control room personnel were informed by the Senior Nuclear Plant Operator (SNPO) on shift that the 1A emergency diesel generator (EDG) fuel oil storage tank had been placed in recirculation. Based on the operators description of the system alignment, the control room supervisor declared the 1A EDG out of service. At 0305 on January 5, 1996, the 1A EDG fuel oil storage tank was correctly placed on recirculation using the approved plant procedure, and the 1A EDG was returned to service.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A) The operator involved in this event was counseled and disciplined in accordance with plant policy.

B) Operations management directed that Operations personnel review and comment on the requirements contained in the Conduct of Operations procedure. The procedure was then revised to implement many of the comments received pertaining to individual responsibilities, communications, and operating practices. The revised procedure along with additional operational policies were provided to the licensed and non-licensed operators on shift for mandatory review.

C) The Operations Manager issued a memo to all operations personnel which discussed this event and outlined immediate changes in operating practices that were to be implemented in order to ensure that events of this nature are not repeated. Emphasis is being given to ensuring that operators in the field do not manipulate plant equipment without understanding the consequences of their actions and ensuring that control room supervision is informed. These expectations have been discussed with the St. Lucie Nuclear Plant Supervisors.

D) To ensure that non-licensed operators are aware of how their actions affect the plant's operation and Technical Specification requirements, FPL will focus non-licensed operators' training on understanding operability requirements for safety and non-safety related systems in various modes of plant operation. This training will begin in the upcoming requalification training cycle 96-04.

5. Full compliance was achieved on January 5, 1996, with the completion of item 3 above.

VIOLATION D:

10 CFR 50, Appendix B, Criterion XI, "Test Control," requires in part that a test program be established to assure that all testing required to demonstrate that components will perform satisfactorily in service and that test results be evaluated to assure that test requirements have been satisfied. FPL Topical Quality Assurance Report 11.0, Rev 4, "Test Control," step 11.2.3, "Evaluation of Test Results," requires that "...documented test results shall be evaluated against the predetermined acceptance criteria by a group or individual having appropriate qualifications."

Contrary to the above, on May 22, 1993, the licensee failed to adequately evaluate Unit 1 CEDM coil resistance test results to assure that test requirements were satisfied as specified in PWO 63/0046 for PC/M 133-191. This resulted in not identifying and dispositioning 11 CEDMs coils whose resistance readings did not meet the specified item #11, Acceptance Criteria of Attachment 4, "PC/M Testing Document."

RESPONSE D:

1. FPL concurs with the violation.

2. <u>REASON FOR VIOLATION</u>

This event was caused by the failure of an instrument and control (I&C) supervisor to fully comply with the approved acceptance criteria which was provided in plant work order (PWO) 63/0046. The intent of the work order was to perform a continuity and insulation test on control element drive motor (CEDM) power supply cables which had been replaced under the Plant Change/Modification (PC/M) Program. The work order was modified and approved to remove a requirement for lifting one lead of the field cable for installation of an ohm meter. Since coil resistance readings were being used only to confirm circuit continuity and not coil performance, the required

resistance measurements could be obtained without lifting the lead. These measurements could yield different resistance readings than would be obtained if the test was performed with the lead lifted as in a coil resistance check. Circuit continuity could therefore be satisfactorily confirmed even though the obtained resistance data may have been outside the acceptance range for coil stack resistance provided in the approved work order. The I&C field supervisor recognized this condition and concluded that comparison of the resistance data to the acceptance criteria to validate cable performance was not necessary to demonstrate compliance with the PC/M post maintenance test requirements. The modified work order, however, did not remove the requirement for verifying that resistance readings were within a required range. Because certain resistance readings did not fall within the acceptance criteria specified in the approved work order, they should have been documented and technically dispositioned.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

FPL compared PC/M 133-191 testing requirements and acceptance criteria to the test results documented in work order 63/0046. It was concluded that an acceptable methodology for determination of cable continuity was used and that the resistance measurements obtained adequately demonstrated that continuity was achieved for all cables. Additionally, the evaluation concluded that the measurements taken were not indicative of any potential problems with the CEDM coils, cables, or connectors. This action was completed on May 10, 1996.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A) The Maintenance Manager reemphasized with Maintenance Department personnel the requirements and discipline consequences stated in FPL Nuclear Division Nuclear Policy (NP) 404, entitled "Procedural Non-Compliance." NP-404 discusses the potential implications to personnel safety, equipment integrity, and the health and safety of the public of not following procedures and procedural requirements.

B) The Maintenance Manager also communicated to department personnel the expectation that the approved St. Lucie plant procedure change process must be followed whenever a task cannot be performed in accordance with existing procedural instructions or if it is determined that changes to a procedure would be beneficial to improving the performance of the task.

C) A detailed task description was developed, which incorporates vendor-supplied CEDM magnetic jack coil resistance tolerance readings and acceptance criteria to support St. Lucie Unit 1 refueling outage work associated with CEDM maintenance. This description provides additional guidance for technicians reviewing and dispositioning coil stack resistance measurements.

D) FPL will be developing a generic guideline for use on both St. Lucie Units 1 and 2 to support future CEDM troubleshooting. This action will be completed by October 31, 1996.

E) The I&C maintenance personnel involved in this event were counseled for the failure to comply with the requirements of their procedure and ensure that all acceptance criteria data was within specifications.

5. Full compliance was achieved on May 10, 1996 with the completion of item 3 above.