CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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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 96-09.Corrective actions:plant dept heads & managers notified that apparent overtime violations,payroll time sheets mods by 961031.

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CATEGORY 1 DOCUMENT

Florida Power & Light Company, P.O. Box 128, Fort Pierce, FL 34954-0128

FPL

September 4, 1996

L-96-217
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 No. 50-335 and 50-389
Reply to a Notice of Violation
Inspection Report 96-09 (EA 96-263)

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,

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

IE01

St. Lucie Units 1 and 2
Docket Nos. 50-335 and 50-389
Reply to a Notice of Violation
Inspection Report 96-09

VIOLATION A:

Technical Specification 6.2.f, requires that the hours expended by personnel performing safety-related functions be limited and that during extended periods of shutdown for refueling, the following guidelines be observed:

- An individual should not be permitted to work more than 16 hours straight, excluding shift turnover time.

- An individual should not be permitted to work more than 16 hours in any 24 hour period, nor more than 24 hours in any 48 hour period, nor more than 72 hours in any 7-day period, all excluding shift turnover time.

The Specification further requires that any deviations from the above guidelines be authorized by the Plant General Manager or his deputy, or higher levels of management, in accordance with established plant procedures and with documentation of the basis for the deviation. AP 0010119, Revision 14, "Overtime Limitations for Plant Personnel," implemented this requirement and provided an administrative vehicle for the approval of deviations from the specified guidelines.

Contrary to the above, during the period from May 13 through June 14, 1996, five individuals who performed safety related functions were found to have contributed to 38 deviations from the 72-hour-in-any-seven-day-period requirement, 15 deviations from the 24-hour-in-any-48-hour requirement, and 3 deviations from the 16-hour-in-any-24-hour-requirement without obtaining authorization from the Plant General Manager, his deputy, or higher levels of management.

This is a Severity Level IV violation (Supplement I).

RESPONSE A:

1. FPL concurs with the violation.

2. REASON FOR VIOLATION

St. Lucie Technical Specifications and Administrative Procedures require that written authorization be obtained, as a minimum, from the Plant General Manager or his deputy prior to exceeding the plant overtime limits. The cause of this violation was a

lack of supervisory and management oversight in the conduct of outage activities, in that overtime limit deviations were not properly forecasted, and deviation requests were not completed to document the departure from overtime limits.

Several additional factors contributed to this event:

1. Management expectations regarding the requirement for pre-approval of overtime guideline deviations were not clear to all station personnel.

2. The Administrative Procedure governing the use of overtime, AP 0010119, "Overtime Limitations for Plant Personnel," Revision 14, was not clear in defining when overtime deviation requests must be completed and approved.

3. Personnel associated with several key outage maintenance activities failed to self identify hours worked in excess of the overtime limits and complete the appropriate overtime deviation request paperwork.

4. Payroll time sheets, as presently formatted, provide insufficient information to permit proper monitoring of hours worked by personnel.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

A. Plant department heads and managers were notified on June 19, 1996, that apparent overtime violations had occurred. Increased attention to overtime monitoring and pre-approval of overtime guideline deviations were emphasized by the Plant General Manager.

B. A Condition Report was written to address the apparent overtime violations. A corrective action which resulted from this was the completion of the required documentation requesting the subject overtime deviations in accordance with plant procedure. This was completed on August 15, 1996.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A. AP 0010119, "Overtime Limits for Plant Personnel," was revised to clarify the circumstances under which an overtime deviation authorization must be obtained and to better define the expectations for personal accountability. This revision was issued on August 23, 1996. This procedure will be further revised

to require that a Plant Condition Report be generated to assess the approval of any deviations from overtime limits. This action will be completed by October 31, 1996.

B. A training bulletin was issued to site supervisory and management personnel regarding the changes made to the overtime procedure, AP 0010119. This bulletin requires discussions with departmental personnel and a statement of understanding and signature to ensure accountability.

C. The St. Lucie security system software is being upgraded to generate a report that will identify potential departures from overtime limits. This action will be completed by October 31, 1996.

D. Payroll time sheets will be modified by October 31, 1996, to incorporate the following four improvements:

1. Documentation of all overtime worked regardless of pay status.

2. Documentation of hours worked six days prior to the payroll period to ensure that for any continuous seven day interval, overtime limits are not exceeded.

3. Documentation of turnover time.

4. A certification by submitter and approver that overtime limits have not been exceeded.

5. Full compliance was achieved on August 15, 1996, with the completion of items 3A and 3B above.

VIOLATION B:

Technical Specification 6.2.f requires, in part, that deviations from overtime guidelines be approved in accordance with established procedures and that controls be included in established procedures such that individual overtime be reviewed monthly by the Plant General Manager or his designee to assure that excessive hours have not been assigned.

Contrary to the above, these requirements were not met in that:

1. Established plant procedures were inadequate to assure that deviations from overtime guidelines would be approved, in that controls included in Administrative Procedure (AP) 0010119, Revision 14, "Overtime Limitations for Plant Personnel," lacked specificity in defining when an overtime deviation request was required, resulting in inconsistencies in application.

2. Established plant procedures were inadequate to assure that proper reviews were performed monthly to assure that excessive hours were not assigned, in that controls included in AP 0010119, Revision 14, "Overtime Limitations for Plant Personnel," did not include an appropriate level of specificity in defining how such a review was to be conducted. Sources of information were not specified, sample size was not defined, and what, if any, records of the reviews' results were to be generated were not defined. As a result, management failed to identify that unauthorized deviations from the overtime guidelines contained in Technical Specification 6.2.2.f were occurring.

This is a Severity Level IV violation (Supplement I).

RESPONSE B:

1. FPL concurs with the violation.

2. **REASON FOR VIOLATION**

The cause of the violation was that St. Lucie management personnel did not adequately assure that the Technical Specification requirements regarding the use of overtime were strictly adhered to. Contributing to this was a procedural inadequacy, in that the Administrative Procedure governing the use of overtime, AP 0010119, "Overtime Limitations for Plant Personnel," assigned responsibilities for monitoring overtime use but provided no detail on how to accomplish this monitoring function. Additionally, the procedure was unclear on the circumstances which would require an overtime deviation request to be completed and approved prior to exceeding the overtime limits.

Several additional factors contributed to this event:

A. Payroll time sheets do not reliably indicate all hours worked. The time sheet reflects only those hours which are to be paid. Exempt employees and non-

bargaining unit employees have the ability to arrange compensatory time off in lieu of pay.

B. Personnel possessing unique skills and experience on key outage activities paid insufficient attention to their hours worked and failed to self-identify the need for authorization of overtime limit deviations.

C. Monitoring of personnel by department heads and managers was inadequate to ensure compliance with Technical Specification requirements.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

A. Plant department heads and managers were notified on June 19, 1996, that apparent overtime violations had occurred. Increased attention to overtime monitoring and pre-approval of overtime guideline deviations was emphasized by the Plant General Manager, and a monthly review of overtime was initiated.

B. AP 0010119, "Overtime Limits for Plant Personnel," was revised to clarify the surveillance requirements and methodology for managing the use of overtime. This revision was issued on August 23, 1996.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A. Payroll time sheets will be modified by October 31, 1996, to incorporate the following four improvements:

1. Documentation of all overtime worked regardless of pay status.

2. Documentation of hours worked six days prior to the payroll period to ensure that for any continuous seven day interval, overtime limits are not exceeded.

3. Documentation of turnover time.

4. A certification by submitter and approver that overtime limits have not been exceeded.

B. Quality Instruction QI 7-PR/PSL-1, "Control of Purchased Material, Equipment and Services," will be revised to require a timely submittal and review of contractor hours worked. This action will be completed by October 1, 1996.

C. This event and the revised requirements for managing overtime limitations will be integrated into contractor orientation training to emphasize personal accountability for overtime control to FPL contractors. This action will be completed by November 30, 1996.

D. St. Lucie security system software is being upgraded to generate a report that will identify potential departures from overtime limits. This action will be completed by October 31, 1996.

E. AP 0010119, "Overtime Limits for Plant Personnel" was changed to reflect that the employee time sheet is the primary means of identifying overtime limit problems, and that the security system will provide a means for department heads to cross-check employee hours.

5. Full compliance was achieved August 23, 1996, with the completion of items 3A and 3B above.

VIOLATION C:

Technical Specification Section 6.8.1.c states that written procedures shall be established, implemented and maintained covering surveillance and test activities of safety related equipment.

Procedure QI 5-PR/PSL-1, Revision 71, "Preparation, Revision, Review/Approval of Procedures," Section 5.11.1, stated, in part, that for maintenance that can affect the performance of safety related equipment, nuclear plant work orders invoking detailed vendor technical manual step-by-step instructions required Facility Review Group review and Plant General Manager approval.

Procedure QI 5-PR/PSL-1, Revision 71, "Preparation, Revision, Review/Approval of Procedures," Section 5.11.3, stated that changes to technical manuals received from the vendor or changes initiated by FPL shall be forwarded to Production Engineering Group/Juno Beach for review and approval.

Procedure QI 5-PR/PSL-1, Revision 71, "Preparation, Revision, Review/Approval of Procedures," Section 5.11.5, stated that maintenance and preventative maintenance requirements specified in technical manuals shall be considered when writing maintenance procedures and that vendor recommendations for preventative maintenance activities or frequencies contained in these Vendor Technical Manuals may be deviated from, provided a technical review is performed by the respective maintenance engineering group.

Contrary to the above, these requirements were not met in that:

1. Maintenance and tests performed during the Unit 1 1996 refueling outage on the Unit 1 reactor cavity pressure relief dampers invoked the use of the vendor's technical manual but did not require that this manual and work order be reviewed by the Facility Review Group and approved by the Plant General Manager.

2. The frequency for the maintenance and tests specified by the vendor manual for the Unit 1 reactor cavity pressure relief dampers was changed from annually to once every 54 months without a technical review by the respective maintenance engineering group.

3. The torque values specified for the Unit 2 reactor cavity pressure relief dampers were changes to vendor specified criteria and were implemented without a technical review by the respective maintenance engineering group. In addition, these changes were not sent to the Production Engineering Group/Juno Beach for review and approval.

This is a Severity Level IV violation (Supplement I).

RESPONSE C:

1. FPL concurs with the violation.

2. REASON FOR VIOLATION

The cause of the violation was cognitive personnel error by utility maintenance personnel who failed to follow plant procedures in the following areas:

A. The level of usage for the technical manual was incorrectly specified within the work package during the planning process. The work description specified that Facility Review Group (FRG) approval was not required when in fact, the vendor manual was being used as a procedure. FRG approval is required prior to use of any vendor technical manual as a procedure. This requirement is specified in plant procedure ADM 0010432, "Control of Plant Work Orders." and in Plant Quality Instruction, QI 5-PR/PSL-1, "Preparation, Revision, Review/Approval of Plant Procedures."

B. The vendor specified maintenance frequency for the St. Lucie Unit 1 dampers was changed without obtaining a documented technical review by the maintenance engineering group. Additionally, a 1987 engineering memorandum which described changes to acceptance criteria and was not approved through a formal engineering process was inappropriately placed in the St. Lucie Unit 2 technical manual and subsequently used during the performance of preventative maintenance on the reactor cavity dampers.

An additional contributing factor was that the reactor cavity pressure relief dampers were not given priority for review in the preventative maintenance basis project due to their lack of failure history. This project reviews and documents the basis for preventative maintenance including any deviations from vendor recommendations.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

A. FPL engineering performed a safety evaluation issued on July 5, 1996, which concluded that elimination of the pressure relief ven[illegible]tion for the St. Lucie Unit 1 reactor cavity dampers (RCD 1&2) from the design basis did not constitute an unreviewed safety question, and that the dampers were no longer required to actuate following a loss of coolant accident (LOCA). The only required function for the Unit 1 dampers is to remain closed, and this function was verified on July 14, 1996, prior to the Unit 1 cycle fourteen start up. The requirement on Unit 1 to perform periodic spring adjustments, calibrations, and testing is no longer applicable.

B. The most recent tests of the Unit 2 reactor cavity pressure relief dampers were completed on October 23, 1995. These tests showed the as found values for reactor cavity damper spring tension to be in compliance with the acceptance criteria specified in the approved vendor technical manual.

C. The unapproved engineering memorandum which changed the vendor's recommended set points was removed from the affected copies of the Unit 2 technical manual (TM 2998-12979). This action was completed on August 22, 1996.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A. Inter-office correspondence letters were issued to maintenance planners and supervisors on July 22, 1996, which re-emphasized the requirements of ADM 0010432, "Control of Plant work Orders," regarding the use of vendor technical manuals and levels of management review. Additionally, the need for personnel to ensure appropriate engineering review of all instructions, notes and vendor letters prior to their use in work packages was stressed.

B. Operating Procedure NOP 1- 0030120, "Prestart Check-off List," will be revised to include the requirement that the reactor cavity dampers be checked closed prior to entry into Mode 4. This action will be completed by October 31, 1996.

C. FPL will perform a detailed review of the PM basis program to ensure that other safety related dampers are included in the program. This review will be completed by December 15, 1996.

D. FPL engineering will perform a safety evaluation to review the pressure relief vent function of the St. Lucie Unit 2 reactor cavity pressure relief dampers. This evaluation will be similar to that performed for Unit 1, and will assess the elimination of the pressure relief function for these dampers on Unit 2. The evaluation will be completed by October 15, 1996.

E. St. Lucie Unit 1 and Unit 2 technical manual requirements for reactor cavity damper spring testing will be revised to reflect the conclusions reached in the engineering safety evaluations. This will be completed by October 31, 1996.

F. A training bulletin was issued to all FPL maintenance disciplines to reemphasize the requirements pertaining to the use of vendor technical manuals. Additionally, this event, and vendor technical manual usage requirements will be integrated into contractor site coordinator training by November 30, 1996.

G. As a part of FPL's continuing maintenance training, usage level requirements associated with vendor technical manuals will be incorporated into Dynamic Learning Activities (DLA) for maintenance personnel by November 30, 1996.

5. Full compliance was achieved on August 22, 1996, with the completion of items 3A, 3B and 3C above.

VIOLATION D:

10 CFR 50 Appendix B, "Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants," Criterion XI, "Test Control," states, in part, that " . . . a test program shall be established to assure that all testing required to demonstrate that structures, systems and components will perform satisfactorily in service is identified and performed in accordance with written test procedures which incorporate the requirements and acceptance limits contained in applicable design documents . . . Test procedures shall include provisions for assuring that all prerequisites for the given test have been met . . . Test results shall be documented and evaluated to assure that test requirements have been satisfied."

Contrary to the above, adequate procedures and controls were not established for the tests performed on the Unit 1 and Unit 2 reactor cavity pressure relief dampers to assure that these dampers would perform satisfactorily in service and meet the requirements specified by the design documents and the vendor's technical manual, in that:

1. Tests of the Unit 1 reactor cavity pressure relief dampers completed on December 7, 1990, indicated that 4 of the 7 damper blades to damper numbers 1, and 3 of the 7 damper blades to damper number 2, failed to meet the acceptance criteria of the vendor's technical manual. The work order records did not indicate that the dampers were adjusted to meet the acceptance criteria.

2. Tests of the Unit 2 reactor cavity pressure relief dampers completed on October 24, 1990, indicated that 4 of the 7 damper blades for damper number 1, and 5 of the 7 damper blades for damper number 2, did not meet the acceptance criteria of the vendor's technical manual.

3. Tests of the Unit 2 reactor cavity pressure relief dampers completed on May 21, 1992, indicated that all 7 damper blades for damper number 2 did not meet

the acceptance criteria of the vendor's technical manual. The work order records did not indicate that the damper was adjusted to meet the acceptance criteria. The test results indicated that damper number 1 was satisfactory.

4. Tests of the Unit 2 reactor cavity pressure relief dampers completed on February 17, 1994, indicated that all 7 damper blades for damper number 1 did not meet the acceptance criteria of the vendor's technical manual. The work order records did not indicate that the damper was adjusted to meet the acceptance criteria. The test results indicated that damper number 2 was not tested.

This is a Severity Level IV violation (Supplement I).

RESPONSE D:

1. FPL concurs with the violation.

2. **REASON FOR VIOLATION**

The cause of the violation was a failure of maintenance foremen and supervisors to follow plant Administrative Procedure ADM 0010432,"Control Of Plant Work Orders." This procedure requires that acceptance criteria data be within specifications. If not, the degraded condition is to be evaluated or corrective action is to be taken using a scope change, a new Plant Work Order or other means. In the instances cited, no additional action was taken to evaluate the condition or to perform rework. In addition, for Unit 2, a 1987 informal engineering memorandum which defined changes to acceptance criteria was used to perform preventative maintenance work. Use of the criteria provided in the memorandum resulted in acceptance of damper spring tension values which did not meet the technical manual acceptance criteria.

One additional factor contributed to the failure to test a damper on February 17, 1994:

1) The Nuclear Plant Work Order (NPWO) instructions lacked clarity which resulted in the maintenance foreman interpreting the NPWO instructions as addressing only one damper (RCD-1). The component number "RCD-2" for the second damper was listed in an attachment to the NPWO. As a result, testing specified to be performed on Unit 2 on February 17,1994 for damper RCD-2 was not completed.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

A. For Unit 1, Engineering Safety Evaluation JPN-PSL-SENP-96-021, Rev. 0 issued July 5, 1996, concluded that elimination of the pressure relief vent function for reactor cavity dampers (RCD-1&2) from the design basis did not constitute an unreviewed safety question and that the dampers were no longer required to actuate following a loss of coolant accident (LOCA). The only required function for the dampers is to remain closed, and this function was verified on July 14, 1996, prior to the Unit 1 cycle fourteen startup. The requirement on Unit 1 to perform periodic spring adjustments, calibrations, and testing is no longer applicable.

B. The most recent tests of the Unit 2 reactor cavity pressure relief dampers were completed on October 23, 1995. These tests showed the as found values for reactor cavity damper spring tension to be in compliance with the acceptance criteria specified in the approved vendor technical manual.

C. The unapproved engineering memorandum which changed the vendor's recommended set points was removed from the affected copies of the Unit 2 technical manual (TM 2998-12979). This action was completed on August 22, 1996.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A. Inter-office Correspondence Letter, "Requirements for Equipment Testing" dated July 22,1996, was issued requiring that all maintenance planners perform a review of work order test activities to ensure compliance with Site Quality Manual test requirements prior to package issuance. Additionally, this requirement is to be incorporated into the Planning Checklist used by the maintenance planners and contained in Administrative Procedure AP 0010432, "Control of Plant Work Orders." This action will be completed by October 31, 1996.

B. Inter-office Correspondence Letter, "Use Of Non-Approved Documents" dated July 22, 1996, was issued to supervisors and planners reaffirming that only "Controlled" technical manuals or portions thereof, may be used in conjunction with Nuclear Plant Work Orders. Any uncontrolled information must receive

technical reviews and approvals in accordance with QI 5-PR/PSL-1 prior to use.

C. A memorandum was issued by the Maintenance Manager to all maintenance supervisors emphasizing strict adherence to acceptance criteria as outlined in ADM 0010432, "Control Of Plant Work Orders". Additionally, this event and the requirements associated with adherence to approved acceptance criteria in plant work orders will be reemphasized in maintenance training. This action will be completed by December 15, 1996.

D. FPL engineering will perform a safety evaluation to review the pressure relief vent function of the Unit 2 reactor cavity pressure relief dampers. This evaluation will be similar to that performed for Unit 1, and will assess the elimination of the pressure relief function for these dampers on Unit 2. The evaluation will be completed by October 15, 1996.

E. St. Lucie Unit 1 and Unit 2 technical manual requirements for reactor cavity damper spring testing will be revised to reflect the conclusions reached in the engineering safety evaluations. This will be completed by October 31, 1996.

5. Full compliance was achieved on August 22, 1996, with the completion of items 3A, 3B and 3C above.

VIOLATION E:

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, Revision 2, February, 1978. Appendix A, paragraph 1.d includes administrative procedures for procedural adherence. QI 5-PR/PSL-1, Revision 71, "Preparation, Revision Review/Approval of Procedures," Section 5.13.1, states that all procedures shall be strictly adhered to.

HP-2, Florida Power and Light (FPL) Health Physics Manual, Revision 10, describes the radiation protection program at FPL's nuclear power plants. The licensee's contamination guidelines are summarized in Table 4.2, "Contamination Guidelines," of the manual. The following contamination limits are described in Table 4.2.

The licensee's contamination limits for materials, tools, equipment and solid waste unconditionally released from the Radiation Control Area (RCA) are:

1,000 dpm/100 cm^2 for loose beta and gamma contamination and

5,000 dpm/100 cm^2 for fixed beta and gamma contamination (direct measurement)

The licensee's contamination limits for tools and equipment used in the RCA are:

1,000 dpm/100 cm^2 for loose beta and gamma contamination and

10 mrem/hr for fixed beta and gamma contamination

Contrary to the above, these requirements were not met in that:

1. On June 18 and 19, 1996, licensee health physics technicians found contaminated tools outside the RCA having contamination levels greater than the unconditional release limits.

   On June 18, 1996, health physics technicians removed 12 M&TE tools from the clean tool room having contamination levels up to approximately 12,500 dpm/100 cm^2 (250 net counts per minute/probe).

   On June 19, 1996, health physics technicians removed five rigging slings from the licensee's clean tool room having contamination levels from approximately 40,000 to 600,000 dpm/100 cm^2 (8,000 to 120,000 dpm/probe).

2. On June 13, 14, and 16, 1996, health physics technicians found tools in the RCA having contamination levels greater than the limits for tools and equipment utilized in the RCA.

   On June 13, 1996, health physics technicians removed nine tools from a temporary hot tool room having loose contamination levels from approximately 1,000 to 20,000 dpm/100 cm^2.

On June 14, 1996, health physics technicians removed five wrenches from the Unit 1 hot tool room having loose contamination in the range of 1,000 to 4,000 dpm/100 cm^2.

On June 16, 1996, health physics technicians removed numerous tools from a temporary hot tool room having loose contamination in the range of 1,000 to 30,000 dpm/100 cm^2.

On June 16, 1996, health physics technicians removed numerous (two bags) of tools from the Unit 1 hot tool room having loose contamination in the range of 1,000 to 120,000 dpm/100 cm^2.

This is a Severity Level IV violation (Supplement IV).

RESPONSE E:

1. FPL concurs with the violation.

2. **REASON FOR VIOLATION**

This violation addressed tools found outside the Radiation Control Area (RCA) that were above the unconditional release limits, as well as tools found inside the RCA tool rooms that were above the procedurally prescribed limits for use in the RCA. The cause of contaminated tools being outside the RCA was a failure of plant personnel to ensure that health physics personnel performed unconditional release surveys prior to removal of the tools from the RCA. Tools found in the RCA tool rooms which were above procedurally prescribed limits were a result of plant personnel returning tools used in contaminated areas to the tool rooms without first having them decontaminated and surveyed by health physics.

Several additional factors contributed to these events:

1) The St. Lucie Maintenance Department had instituted more stringent controls over tool issue and accountability. In an effort to reduce the number of lost tools, personnel were required to log each tool out, and then back in following use. Failure to log an item back into inventory could result in the person being held responsible for loss of that item. This resulted in personnel returning

tools to the tool room which were potentially contaminated above procedural limits to ensure that the tools were logged in and accounted for.

2) There were no personnel assigned full time to operate the tool decontamination area. This resulted in a reluctance of personnel to simply drop off the tools at the decontamination area, as there were no provisions to allow the tools to be logged back into inventory prior to their being decontaminated.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

A. To address the issue of contaminated tools outside of the RCA, the following corrective actions were taken:

1. All items found to be contaminated, as described in the above violation, were immediately returned to the RCA. This action was completed by June 19, 1996.

2. A site-wide inspection was made of areas outside the RCA, where tools and equipment which could have been used in the RCA are stored, to ensure that no additional contaminated items existed. Eight additional items were found during the inspection which did not meet the requirements for unconditional release, and were therefore returned to the RCA. This action was completed on July 7, 1996.

3. Supervisors from Instrument and Control (I&C), Electrical, and Mechanical maintenance disciplines were req[illegible] to conduct stand down meetings with their crews to discuss this incident.

4. A procedure change was implemented to HPP-4, "Scheduling of Health Physics Activities," which increased the frequency of surveys in the designated secondary side tool storage area from monthly to weekly. Surveys performed in this area are more thorough than in the past, with emphasis on items known to be used in the RCA.

5. Work stand down meetings were held with health physics personnel to stress the importance of performing thorough unconditional release surveys, including adequate searches of all vehicles leaving the RCA to identify any items not readily visible.

B. To address the matter of tools found above the procedural limits in the RCA tool rooms, the following corrective actions were taken:

1. Extensive surveys were performed to ensure that the contamination levels of all tools located in the tool issue areas were within procedural limits. All tooling found to be above these limits were returned to the appropriate decontamination area. This action was completed by July 1, 1996.

2. A plant Condition Report was generated which resulted in RCA tool room personnel being instructed not to place any tooling back on the shelf for reissue, regardless of whether the tool was used in a clean or contaminated area. A lay down area was designated in each tool room to be used as a holding area for returned tooling until health physics surveys can be performed.

3. Work stand down meetings were held with health physics personnel to ensure that the new tool return policy was strictly enforced.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

A. This violation was discussed at the Unit 1 outage critique meeting held on August 8, 1996. As a result, the mechanical maintenance tooling supervisor will be working with the Health Physics Department to develop written policies governing tool issuance and responsibilities. This action will be completed by December 15, 1996.

B. St. Lucie Health Physics Department will work with the Maintenance Department to reduce the amount of tooling located in the RCA. This will allow more thorough and efficient surveys to be performed. This action will be completed by December 15, 1996.

C. A task team will be formed to generically address the issue of site tool control. The team will address both outage and non-outage control of tools. Additional long term corrective actions will be evaluated to enhance the positive control measures for tooling both inside and outside the RCA. This action will be completed by December 15, 1996.

D. This event and the procedural requirements for the removal of materials from the RCA will be incorporated into the maintenance continuing training program. This action will be completed by December 15, 1996.

5. Full compliance was achieved on July 7, 1996 with the completion of items 3.A.1, 3.A.2 and 3.B.1, above.