

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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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 50-335/96-15.
Corrective actions: updated measuring & test equipment log,
briefed instrument & control dept on event & revised Quality
Instruction QI 12-PR/PSL.

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DEC 04 1996
L-96-315
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
Reply to a Notice of Violation
NRC Inspection Report 96-15

Florida Power and Light Company has reviewed the subject inspection report, and pursuant to 10 CFR 2.201 the responses to the violations are attached.

We share your concern with the progress of ongoing efforts to instill, at all levels of the organization, the culture of strict compliance with procedures and attention to detail. Be assured we are continuing to reinforce these cultural attributes at every available opportunity, and are continuing to conduct periodic stand down meetings, when appropriate. An additional key to the establishment of these cultural attributes is our commitment to the completion of the procedure upgrade program. This comprehensive program is intended to ensure that our employees have the right procedural tools available for their use.

Very truly yours,

T. F. Plunkett
President - Nuclear Division

TFP/JAS/PTQ

Attachment

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

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I-001

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PDR ADOCK 05000335
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Attachment
Reply to a Notice of Violation

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, Revision 2, February, 1978. Appendix A, paragraph 8.a includes procedures to ensure that tools, gauges, instruments, controls, and other measuring and test devices are properly controlled. Procedure QI 12-PR/PSL-2, Revision 22, "Control And Calibration Of Measuring And Test Equipment (M&TE)," Section 5.3.4.A states, in part, that each item of M&TE shall have a log sheet filled out to identify each activity where the instrument was used.

Contrary to the above, on June 26, 1996, Measuring and Test Equipment item PSL-865, was used to perform maintenance in accordance with Work Order 95031787, without identifying the activity where the instrument was used on the log sheet.

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

Response A:

1. FPL concurs with the violation.

2. REASON FOR THE VIOLATION

The cause of this violation was cognitive personnel error on the part of utility Instrument and Control (I&C) personnel who failed to adhere to the requirements of Quality Instruction QI 12-PR/PSL-2, "Control and Calibration of Measuring and Test Equipment." The procedure requires that M&TE be logged to each activity where the instrument was used. An I&C technician used megohmmeter PSL-865 for a confirmatory measurement and as a back-up to an instrument that had been properly logged out to the Nuclear Plant Work Order (NPWO). The technician understood the requirements of QI 12-PR/PSL-2. However, due to an oversight, the I&C technician failed to log the confirmatory instrument into the M&TE log.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

A) The M&TE log was updated on November 15, 1996 to include the use of megohmmeter PSL-865 to perform work order 95011787 (NPWO 4546/63).

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- B) The Instrument and Control department supervisors and technicians were briefed on this event and on the requirements of QI 12-PR/PSL-1 "Calibration of Measuring and Test Equipment" and QI 12-PR/PSL-2 "Control and Calibration of Measuring and Test Equipment".

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

- A) Quality Instruction QI 12-PR/PSL-2 was revised in August, 1996, to state that "Borrowing of M&TE in the field is not an acceptable practice." This Quality Instruction and the above violation are being included in the fourth quarter I&C Industry and In-house Events training program to further emphasize M&TE control requirements.
- B) On September 17, 1996, a memorandum was issued to all maintenance personnel (MGMT/PSL Ltr. Bk. #96-102) which instituted additional controls for access to M&TE. The additional controls include locking of M&TE storage areas and access restrictions to areas in which M&TE is stored. The requirement to ensure that all M&TE is properly assigned to a specific Nuclear Plant Work Order was emphasized.
5. Full compliance was achieved on November 15, 1996, when the M&TE log was updated to include the use of megohmmeter PSL-865 to perform work order 95011787 (NPWO 4546/63).

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, Revision 2, February, 1978. Appendix A, paragraph 1.d includes administrative procedures for procedural adherence. Procedure QI 5-PR/PSL-1, Revision 73, "Preparation, Revision, Review/Approval Of Procedures," Section 5.14.1 requires verbatim compliance to procedures by all personnel. In addition, step 5.14.4.A.3 requires that procedures containing tasks which must be performed in a specified sequence and/or which verification is documented by initial or signature must be present and referred to directly during the performance of the activity.

Contrary to the above, on September 14, 1996, a health physics technician performing a grab sample of the Unit 1 containment failed to have Procedure HPP-22, Revision 4, "Air

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Sampling", Appendix A, in hand, while it was being performed. As a result, step 7.21 of this procedure was not performed which rendered the containment radiation monitor inoperable.

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

Response B:

1. FPL concurs with the violation.

2. REASON FOR THE VIOLATION

The cause of this violation was cognitive personnel error on the part of a Health Physics Radiation Protection Man (RPM) performing a grab sample of the Unit 1 containment atmosphere in preparation for a containment entry to support Instrument and Control department work activities. The sample was being taken via the Unit 1 Particulate Iodine Gas monitor in accordance with health physics procedure HPP-22 "Air Sampling".

Specifically, the RPM performing the sample did not have procedure HPP-22 in hand as required when realigning the monitor to normal operation. The RPM felt that he had the steps of the procedure memorized. This led to missing a key step in the procedure, which resulted in the monitor being declared back in service with the throttle valve in the incorrect (closed) position.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

- A) Upon discovery that the containment radiation monitor was inoperable, the RPM placed the throttle valve in the correct position and the Senior Nuclear Plant Operator verified that the monitor was back in service. This action was completed on September 14, 1996.
- B) Health Physics (HP) management performed an investigation of the event and concluded that the event was caused by personnel error. Disciplinary action was determined as appropriate for the situation and administered in accordance with FPL policy. The individual's RPM qualification was suspended until successful remedial training could be completed.
- C) Health Physics procedure HPP-22 was reviewed by HP management personnel for adequacy and potential human factors issues that may have contributed to the event.

It was concluded that use of the procedure would have been adequate to prevent the above violation.

- D) Stand down meetings were conducted with HP personnel to discuss the event and review the requirements of HPP-22. The requirement to have the procedure in hand while performing the task was stressed.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

- A) Health Physics Procedure HPP-22 was revised to emphasize the requirement to perform Independent Verification for correct valve positioning prior to declaring the monitor back in service. HPP-22 is the only Health Physics procedure that involves taking a piece of equipment out of service. This procedure change was completed and issued on September 27, 1996.
 - B) The RPM involved in the event successfully completed a remedial training program and was reinstated as an RPM on November 22, 1996. The remedial training consisted of procedural study, a written exam, an oral exam, and on-the-job training with qualified personnel. This was followed by a face-to-face meeting with the Site Vice President concerning procedural adherence and attention to detail.
 - C) HP personnel received additional training on the requirements of HPP-22. The training stressed the requirement to have the procedure in hand when performing the task and the expectation of verbatim compliance. This training was completed on November 12, 1996. FPL is continuing to reinforce a culture of strict compliance with procedures and attention to detail, and is continuing to conduct periodic stand down meetings, when appropriate.
5. Full compliance was achieved on September 14, 1996, with the completion of item 3A, above.