

CATEGORY 1

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SUBJECT: Responds to violations noted in insp repts 50-335/97-06 & 50-389/97-06. Corrective actions: evaluated work performed under Condition Rept 97-0028 & found acceptable & developed stand-alone troubleshooting procedure.

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September 24, 1997

L-97-227
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 a Notice of Violation
NRC Integrated Inspection Report 97-06

Florida Power and Light Company (FPL) has reviewed the subject Notice of Violation and, pursuant to 10 CFR §2.201, the responses to the violations are attached.

Since the late calendar year 1996 violation in which a scope change was improperly made to a nuclear plant work order, St. Lucie Plant has strived to improve the conduct of maintenance in the plant. Significant improvements are being made to the plant's work process. A stand-alone troubleshooting procedure was developed, and additional procedural guidance on nuclear plant work order scope changes is being developed.

Concerning the violation for untimely corrective action, we have determined that the 1996 change by St. Lucie Plant to the Condition Report process, which has been in use for several years at Turkey Point, will prevent similar future violations. The importance of the fire penetration seal corrective actions were not recognized during the conversion of the previous program, or STARS, to the current Condition Report and Plant Manager Action Item process. The St. Lucie Quality Assurance Department is performing an independent assessment on the conversion process to determine if corrective actions may have been missed during the early 1996 transition period.

Please contact us with questions on the enclosed violation responses.

Very truly yours,

Thomas F. Plunkett
President
Nuclear Division

TFP/JAS/EJW

Attachment



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

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PDR ADOCK 05000335
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Violation A

10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, requires in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances.

A scope change was made to nuclear plant work order (NPWO) 2830 on November 20, 1996 which contained step by step instructions for performing testing/troubleshooting activities to demonstrate, in part, the operability of the 125 volt dc bus cross tie circuit breaker.

Contrary to the above, the testing/troubleshooting activities were not performed in accordance with procedures of a type appropriate to the circumstances in that the step by step instructions contained in the scope change to NPWO 2830 did not provide adequate details for the testing/troubleshooting activities being performed. The scope change did not adequately delineate testing prerequisites and was not appropriately integrated with the other work control documents being used for this evolution. For example, it was not clear which steps of the original work order were to be completed prior to performing the steps in NPWO 2830. Also, it was not clear which of the breakers was to be worked.

This is a Severity Level IV violation (Supplement I) applicable to Unit 1.

Response A

1. FPL concurs with the violation.
2. REASON FOR VIOLATION

FPL identified a deficiency regarding the failure to establish surveillance testing procedures to ensure the operability of the DC bus tie breakers during FPL's preparation for the NRC's Architect Engineer Design Inspection. During on-line testing of these breakers, a failure was noted on the undervoltage (UV) device. This failure necessitated troubleshooting within a Technical Specification ACTION statement for the affected 1C AFW pump, which was accomplished by scope change 1A to the NPWO. The original NPWO was a contingency for additional bench testing/troubleshooting of a failed functional test. Just prior to functionally testing the 125 VDC breaker, a decision was made to perform additional testing/troubleshooting of the breaker in place, instead of bench testing as the original NPWO scope outlined. The field scope change 1A, written by Electrical Technical Support, was to allow in place testing/troubleshooting with an energized DC bus.



The specific scope change was performed by a technical support person who was a subject matter expert. Detailed scope change instructions were felt to be unnecessary since supervisory oversight was provided, and because the work to be performed was considered to be within the skill of the craft. However, the existing procedural guidance for scope changes was inadequate. Plant Administrative Procedure ADM 0010432 Rev 7, "Control of Plant Work Orders," did not contain sufficient information on minimum requirements for performing a scope change to a NPWO and did not contain instructions or guidance for the use of direct supervision and technical oversight while performing work. Additionally, at the time of this condition, St. Lucie Plant did not have a stand-alone troubleshooting procedure.

3. **CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED**

- A. The work performed was evaluated under Condition Report 97-0028, and was found to be acceptable.
- B. A stand-alone troubleshooting procedure, GMP-21, "Troubleshooting Process," was developed and approved on March 10, 1997.
- C. A training bulletin was provided to Maintenance supervision on April 15, 1997, for the NPWO field scope change process, and when to solicit assistance from the NPWO planners.

4. **CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS**

- A. Plant Administrative Procedure ADM 0010432, "Control of Plant Work Orders," will be further clarified to include additional guidance on the level of detail required when performing a field scope change to NPWOs by October 10, 1997.
 - B. Additional training will be provided to Maintenance supervisors and technical support personnel on the level of detail to use when preparing scope changes to NPWOs, and when to solicit review and preparation support by the NPWO planners by October 20, 1997.
5. Full compliance was achieved on August 25, 1997, with the completion of items 3.B and 3.C above.

Violation B

Technical Specification Section 6.8.1 states that written procedures shall be established, implemented, and maintained covering the fire protection program implementation.

Final Safety Analysis Report (FSAR) Appendix 9.5A Section 8, Quality Assurance Program, states that the QA program for fire protection is a part of the overall company QA program and is contained in the Florida Power and Light Topical Quality Assurance Report (FPL TQR).

FPL TQR Section 16.1 states that documented measures shall be used to assure that conditions adverse to quality such as failures, malfunctions, deficiencies, deviations, defective materials and equipment and nonconformances are promptly identified and corrected as soon as practical.

Contrary to the above, in January 1995, corrective action was not initiated to resolve as soon as practical the 222 out of 365 mechanical fire barrier penetration seals installed in various safety related areas of the St. Lucie facility in which a licensee's engineering evaluation determined were not bounded by the vendor's design and test documentation.

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

Response B

1. FPL concurs with the violation. However, the number of unbounded mechanical fire barrier penetrations is 218, not the 222 stated in the notice of violation. It appears as though penetrations in more than one discrepancy list resulted in those penetrations being counted more than once.

2. REASON FOR VIOLATION

The apparent cause of this event was weaknesses associated with the previous problem identification and corrective action process, STAR, in place during the original IN 94-28 review. An operability assessment on the condition of the 218 fire penetration seals was not performed under the STAR program, and the need for field modifications was not identified. The original STAR only identified the need to perform additional evaluations. The importance of these evaluations was not recognized during the STAR to Condition Report (CR) and Plant Manager Action Item (PMAI) conversion that occurred in early 1996. The St. Lucie STAR program was subsequently replaced by the CR process. The CR procedure ensures that operability determinations are performed for potentially

degraded Systems, Structures, and Components (SSCs), and provides positive tracking mechanisms for required corrective actions.

3. **CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED**

- A. A Condition Report was generated to document this condition. FPL personnel performed an operability assessment for the 218 penetration seals that were not directly bounded by test data. Of this population, the operability assessment has shown that seven penetration seals in Unit 1 and eight penetration seals in Unit 2 are inoperable. These inoperable penetration seals have had Fire Breach Permits generated and posted in the area of the seal and are being monitored by the hourly roving fire watch as required by the Appendix "R" Fire Protection Program at St. Lucie. It should be noted that the routing of the existing hourly fire watches did not need to be changed to accommodate the inoperable fire seal penetrations.
- B. St. Lucie is currently developing a schedule to complete Generic Letter 86-10 mechanical fire penetration evaluations which will be performed for the 218 mechanical seals that are not bounded by tested configurations.
- C. St. Lucie is currently developing a schedule to develop modifications of the inoperable mechanical fire penetrations to ensure that the three hour fire barrier criteria will be met.

4. **CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS**

- A. The previous problem identification and corrective action program, the St. Lucie STAR procedure, was replaced with the Condition Report procedure (Plant Administrative Procedure AP-0006130, "Condition Reports").
- B. Operating Experience (OE) items which are determined to require review by St. Lucie Plant are now addressed using the St. Lucie Plant Condition Report process. Condition Reports are used to document the evaluation and corrective actions for such applicable OE items and provide a vehicle to assure that proper evaluations are completed and documented, and that corrective actions are properly captured and tracked to completion. The Condition Report process produces standardized responses to OE items, ensures timely and enhanced visibility of OE reviews, and establishes minimum standards for documentation, review, and approval. (Plant Administrative Procedure ADM-17.03, "Operating Experience Feedback")

- C. The Quality Assurance Department is performing an independent assessment by sampling past STAR to CR and Plant Manager Action Item (PMAI) conversions to determine if any corrective actions may have been missed in the conversion. This activity will be completed by the beginning of the 1997 Unit 1 SL-15 refueling outage.
 - D. The Engineering Department supervisors recently reviewed and prioritized all open Plant Management Action Items (PMAIs) assigned to Engineering based on safety or regulatory significance. While not included as a discrete activity within the scope of the PMAI review, FPL is confident that the review provided assurance that additional OPERABILITY concerns which should have been identified in STARS were not missed in the 1996 STAR to CR and PMAI conversion process.
5. Full compliance with 10 CFR 50 Appendix R requirements was achieved on July 28, 1997 when the 15 inoperable mechanical fire barrier penetrations were included in the existing hourly roving fire watch patrols.