

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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FACIL: 50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co.
50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co.
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RECIP. NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

DOCKET #
05000335
05000389

SUBJECT: Submits response to violations noted in insp repts
50-335/97-14 & 50-389/97-14. Corrective actions: SG
replacement project personnel alerted to St Lucie plant
procedural requirements on planned deviations of TS limits.

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FEB 26 1998

L-98-039
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 97-14

Florida Power and Light Company (FPL) has reviewed the subject Notice of Violation and, pursuant to 10 CFR §2.201, the response to violations B and C are attached. NRC Inspection Report 97-14 stated that no response to violation A was required since the corrective actions taken and planned to correct the violation and prevent recurrence, and the date when full compliance was achieved, were adequately addressed on the docket.

With respect to violation B, inadequate oversight of contractors by FPL personnel during the St. Lucie Unit 1 Steam Generator Replacement Project (SGRP) resulted in a failure to properly implement plant procedural requirements for documenting and approving planned exceedances of the Technical Specification limits on overtime. St. Lucie site management will ensure that the lessons learned in regard to the level of contractor oversight required to perform at high levels from the SGRP outage are applied to future refueling outages.

With respect to violation C, personnel errors continue to dominate the cause of performance shortcomings at St. Lucie. I personally have discussed the unacceptability of continuing personnel errors with the management team and the nuclear plant supervisors at the plant. I have stated my expectations for error-free performance in all activities and the consequences for not meeting my expectations. To prevent future personnel errors, the plant is emphasizing self and peer-checking in addition to its focus on verbatim procedural compliance. This is clearly an area which requires focus and action by the plant managers and staff in the future.

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PDR ADDCK 05000335
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Please contact us with questions on the enclosed violation responses.

Very truly yours,

Thomas F. Plunkett

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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Violation B

Section 6.2.2.f of both units' Technical Specifications state, in part, that "Administrative procedures shall be developed and implemented to limit the working hours of unit staff who perform safety-related functions." Additionally, "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." Furthermore, the Technical Specifications require that "Any deviation from the above guidelines shall be authorized by the Plant General Manager or his deputy, or higher levels of management."

Contrary to the above, deviations from the overtime guidelines were routinely authorized by the Steam Generator Replacement Project Director rather than the Plant General Manager or his deputy, or a higher level of management during the 1997 Unit 1 Steam Generator Replacement and Refueling Outage. This included deviations on October 21, and December 1, 1997.

This is a Severity Level IV violation (Supplement I) applicable to both Units.

Response

1. FPL concurs with the violation.

2. REASON FOR VIOLATION

The reason for this violation was inadequate contractor oversight by Florida Power & Light Company (FPL) personnel. The replacement of the St. Lucie Unit 1 steam generators was a major construction project and a separate organization was established for the project. The Steam Generator Replacement Project (SGRP) organization was separate from, but matrixed with, other plant departments. SGRP contractor work procedures were reviewed and approved by FPL. During the SGRP, the plant's overtime procedure was revised to address SGRP personnel and, specifically, the applicability of Technical Specification overtime limits to SGRP personnel. Revision 1 to the SGRP overtime guidelines identified that SGRP Quality Assurance, Engineering, and non-destructive examination (NDE) personnel were subject to the St. Lucie overtime requirements, including the required approval authority for exceeding overtime limits.

St. Lucie Plant administrative procedures require that personnel subject to the Technical Specification limits on overtime document requested overtime deviations in a waiver letter that is approved by the St. Lucie Vice President or Plant General Manager. Additionally, the procedure requires that a Condition Report (CR) be written for each requested waiver

to document the deviation, its cause, and corrective actions. The SGRP Director, a contracted employee, incorrectly concluded that SGRP personnel who had been designated as being subject to the Technical Specification limits on overtime and the associated St. Lucie Plant administrative procedure, but were not performing safety-related work, could have overtime deviations approved in accordance with the SGRP overtime guidelines. In certain cases, deviation forms for applicable SGRP personnel had been approved by the SGRP director, and not by the St. Lucie Vice President or Plant General Manager, as required by plant procedure. Additionally, in some cases, CRs were not written for some events for which deviation forms had been submitted for approval.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

- A. The SGRP director was counseled on the plant's and SGRP's procedural requirements for obtaining approval for exceeding the Technical Specification limits on overtime.
- B. SGRP personnel were alerted to the St. Lucie Plant procedural requirements on planned deviations of the Technical Specification limits on overtime. Subsequent to December 5, 1997, deviations from the Technical Specification limits on overtime for affected SGRP personnel were approved by the St. Lucie Vice President.
- C. Additional levels of contractor oversight were provided by the FPL Quality Assurance Department to ensure procedural compliance by the Steam Generator Team.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

- A. Management expectations concerning FPL oversight of contractors will be reinforced during the site wide pre-outage stand down meetings. FPL field coverage of contractors and adherence to FPL procedures by contractors will be one of the topics covered in these meetings.
 - B. FPL is revising and enhancing its contract coordinator training program; this event will be included in contractor coordinator training by July 31, 1998.
5. Full compliance with the St. Lucie overtime requirements by the SGRP was met on December 5, 1997, with the completion of corrective action 3.B. above.

Violation C

Technical Specification 6.8.1 requires that the licensee implement and maintain the procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, 1978 including locking and tagging of equipment.

Procedure ADM-09.04, Revision 2, "In-Plant Equipment Clearance Orders," Section 6.15.10 stated that boundary modifications should be processed using the computer system.

Procedure ADM-09.04, Revision 2, "In-Plant Equipment Clearance Orders," Section 6.1.17 allowed a system with an unisolable clearance provided that "Parameters are being maintained by the Operations shift for control of protective conditions."

Contrary to the above,

1. On November 16, 1997, the Clearance Center Supervisor failed to process a boundary modification using the computer system. An Equipment Clearance Order Boundary Modification was implemented using only the hard copy of the clearance. A difference in the two versions of the clearance order led to the valve being left open after returning the system to service.
2. On December 16, 1997, the licensee chose to implement an unisolable clearance but did not maintain parameters for the control of protective conditions. A tagless clearance was established to allow filling the Reactor Coolant System to 29 feet 6 inches. However, the level in the Reactor Coolant System was subsequently raised to 30 feet.

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

Response

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

The reason for the first example of this violation was cognitive personnel error by the Assistant Nuclear Plant Supervisor (ANPS) and Senior Nuclear Plant Operator (SNPO). The clearance procedure requires that after a clearance boundary is established, all subsequent clearance boundary modifications and releases for test are to be performed

using the computer record of the clearance "as hung" in the field. Contrary to this procedure, the ANPS modified the original clearance boundary on the hard copy of the equipment clearance order (ECO) to allow for the opening of a drain valve to permit pipe purging to remove hydrogen from the piping within the work boundary. The drain valve was removed from the hard copy clearance, without updating the clearance computer database, to allow manipulating the valve under a letter of instruction (LOI) that was developed to control the gas purging evolution. The ANPS failed to update the computerized record of the ECO to reflect the modified clearance boundary.

Post-modification testing required modifying the clearance boundary, so a clearance release for test (RFT) was generated based on the erroneous computerized clearance database, which showed the drain valve position as tagged open. When the RFT was subsequently released, the drain valve was tagged open in accordance with the erroneous clearance computer database. The ECO was later released using the hard copy of the clearance, and the drain valve remained tagged open in the field. This resulted in a hydrogen leak in the reactor auxiliary building via the open drain valve.

Additionally, the failure to update the computerized clearance database should have been identified by the SNPO who hung the clearance RFT boundary modification. The SNPO that hung the clearance RFT boundary modification should have identified the failure to update the computerized clearance database and should have reported that the drain valve was found closed, not tagged open, as expected on the clearance RFT boundary modification.

The reason for the second example of this violation was a procedural inadequacy within ADM-09.04, Revision 2, "In-Plant Equipment Clearance Orders" in that a caution tag was inappropriately permitted by procedure to implement a clearance. In order to allow maintenance on the primary manways, an unisolable system clearance was hung on the reactor coolant system (RCS). The clearance included the following statement:

This is an ECO for an unisolable system. Parameters are being maintained by the Operations shift for control of protective conditions. DO NOT RAISE RCS LEVEL ABOVE 29' 6" PRIMARY MANWAYS BEING INSTALLED.

A caution tag was placed on the tygon tubing that stated:

Do not raise level greater than 29' 6" without ANPS/NPS permission

There was no procedural requirement that the caution tag reference the clearance order. When control room supervision was notified that the primary manways were installed, they did not understand that the caution tag was related to an unisolable clearance order.

Subsequently, the ANPS authorized increasing RCS level greater than 29' 6". RCS level was increased to 30' before the source of the caution tag was recognized.

3. CORRECTIVE STEPS TAKEN AND THE RESULTS ACHIEVED

For the first example (failure to update computer clearance database):

- A. The drain valve was closed on November 27, 1997, and a system lineup was conducted on the portion of the reactor auxiliary building hydrogen system that was potentially affected by the clearance.
- B. Stand down meetings were held with Operations personnel to discuss the event, and emphasize the need for keeping the hard copy and computerized clearance database identical.
- C. The ANPS and SNPO involved with the clearance error were disciplined.
- D. Procedure ADM-09.04, "In-Plant Equipment Clearance Orders," was revised to require a walkdown (or procedural lineup) of major flowpath valves and components within the boundary of all clearances when the clearance is released.

For the second example (unisolable system clearance):

- E. The clearance was released on December 17, 1997.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

For the first example (failure to update computer clearance database):

- A. The process used to procedurally change clearances is under review. This effort includes coordination with FPL's other nuclear facility, Turkey Point. This review will be completed by April 30, 1998.
- B. The need to revise the computer clearance software to allow deletion of individual clearance tags is currently being tracked on the 10 highest priority safety items list. This will correct the manual workaround required to change the computer clearance database. The revision to the computer clearance software, and associated procedure changes, will be completed by June 30, 1998.

For the second example (unisolable system clearance):

- C. Procedure ADM-09.04, "In-Plant Equipment Clearance Orders," was revised to require the use of a clearance information tag, including the clearance order number, on the instrument being used to control the parameter.
5. Full compliance with the clearance procedure was reached on December 17, 1997, with the completion of corrective action 3.E. above.

