CATEGORY

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

Document Control Branch (Document Control Desk)

R

Y

 \mathbf{E}

ACCESSION NBR:9706260099 DOC.DATE: 97/06/19 NOTARIZED: NO DOCKET #
FACIL:50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co.
50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co.
AUTH.NAME AUTHOR AFFILIATION
STALL,J.A. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: Forwards "St Lucie Plant Status Meeting for Units 1 & 2."

DISTRIBUTION CODE: A001D COPIES RECEIVED:LTR | ENCL | SIZE: 68
TITLE: OR Submittal: General Distribution

NOTES:

	RECIPIENT ID CODE/NAME PD2-3 LA WIENS,L.	COPIE LTTR 1 1		RECIPIENT ID CODE/NAME PD2-3 PD	CÒPI · LTTR 1		٠	
INTERNAL:	ACRS NRR/DE/ECGB/A NRR/DRCH/HICB NRR/DSSA/SRXB OGC/HDS3	1 1 1 1	1 1 1 0	PILE CENTER 0 NRR/DE/EMCB NRR/DSSA/SPLB NUDOCS-ABSTRACT	1 1 1	1 1 1 1	•	h
EXTERNAL:	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!





June 19, 1997

L-97-164 10 CFR 50.4

A 00111

U. S. Nuclear Regulatory Commission

Attn: Document Control Desk

Washington, DC 20555

RE:

St. Lucie Units 1 and 2

Docket Nos. 50-335 and 50-389

Management Review Meeting - June 1997

During a November 1995 meeting with the NRC, Florida Power and Light Company (FPL) reviewed the progress made in completing activities outlined in the St. Lucie Plan to Improve Operational Performance. FPL stated that meetings to review performance would be held monthly. In the November meeting, FPL committed to provide the monthly review materials to the NRC.

Enclosed is a copy of the indicators issued in June 1997 for St. Lucie Plant. The indicators were discussed at the June 13, 1997, FPL management review meeting at St. Lucie.

We look forward to NRC presence and feedback at these monthly meetings. If you have any questions on this material, please contact us.

Very truly yours,

J. A. Stall

Vice President St. Lucie Plant

JAS/spt

Enclosure

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

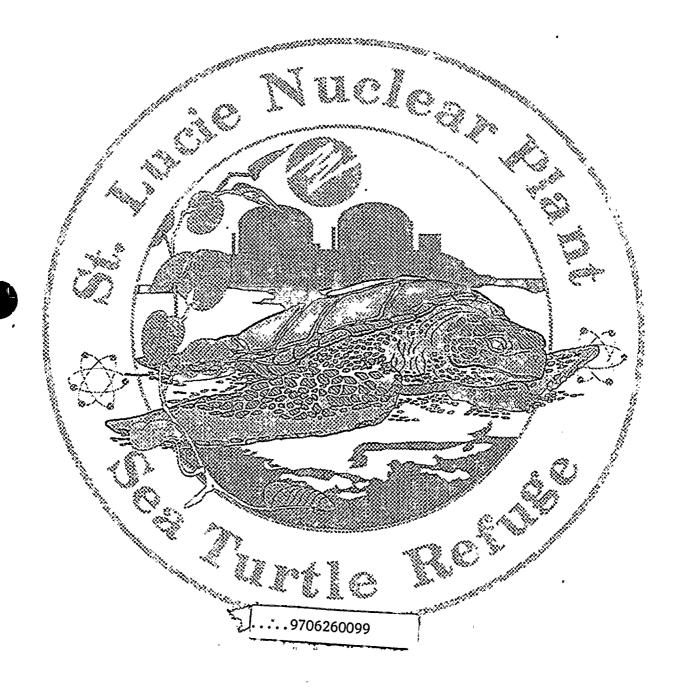
9706260099 970619 PDR ADDCK 05000335

260008



it , B -7 ਮੈਂ ਖ_੍ਬ

St. Lucie Plant Status Meeting



June 13, 1997

,

.

St. Lucie Status Meeting Agenda

Operating Report H. Johnson

Work Control C. Wood

Operations H. Johnson

Maintenance J. Marchese

Engineering C. Bible

Services D. Fadden

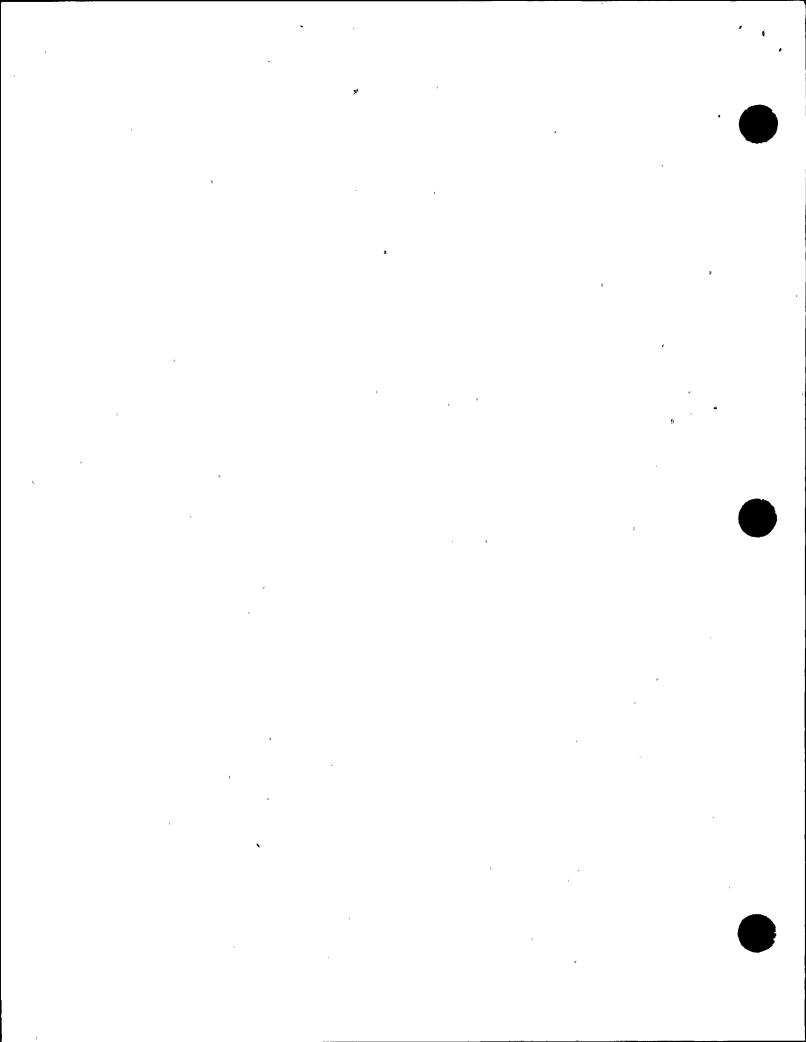
Materials Management G. Boissy

Business Systems R. Heroux

Steam Generator Replacement Project R. Daley

Licensing E. Weinkam

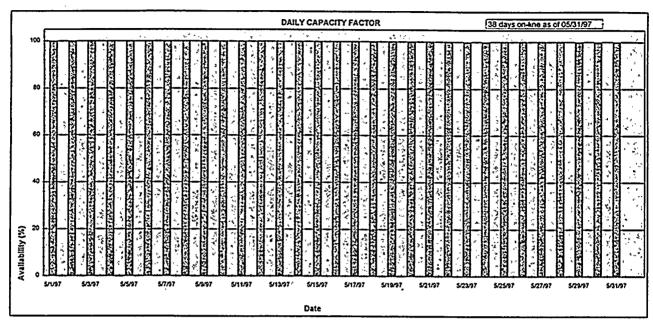
Quality Assurance W. Bladow



OPERATING REPORT

Hugh Johnson

Unit 1
Equivalent Availability

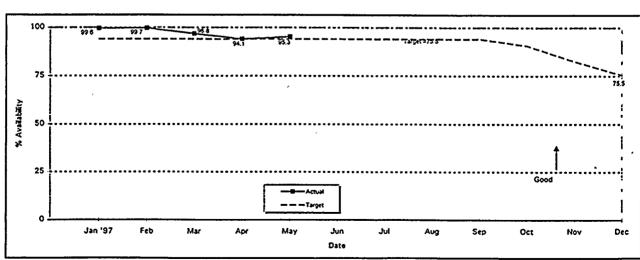


Lost Generation

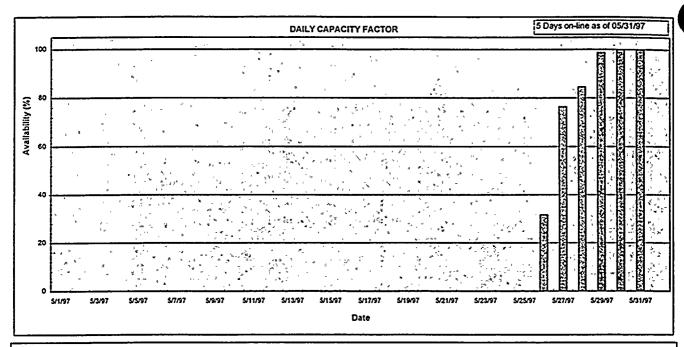
Date MWH Loss Reason

Based on a Maximum Dependable Capacity of 839 M/A

EQUIVALENT AVAILABILITY FACTOR - UNIT 1

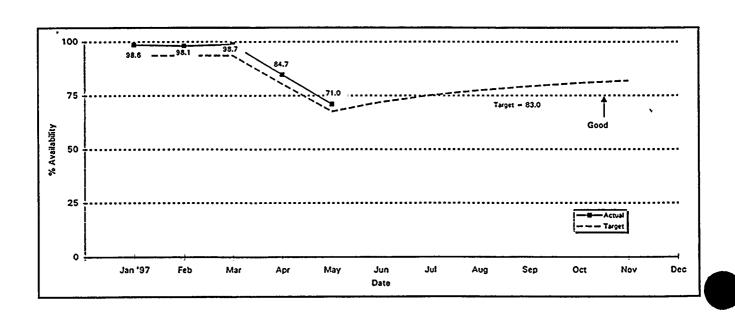


Unit 2
Equivalent Availability

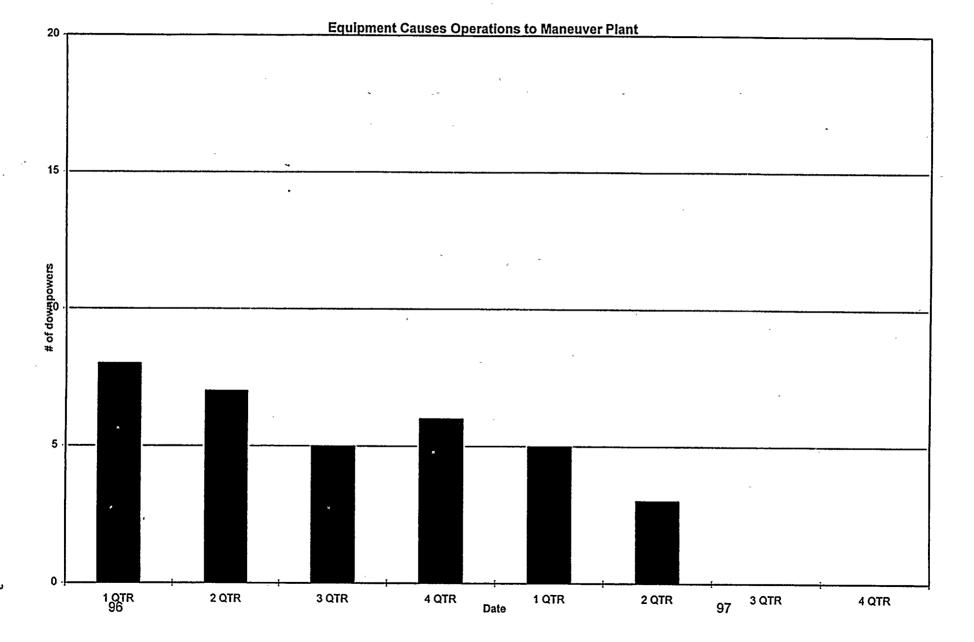




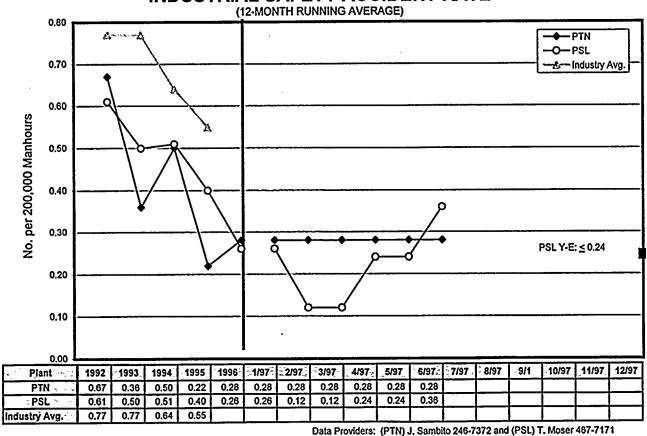
Based on a Maximum Dependable Capacity of 839 MW



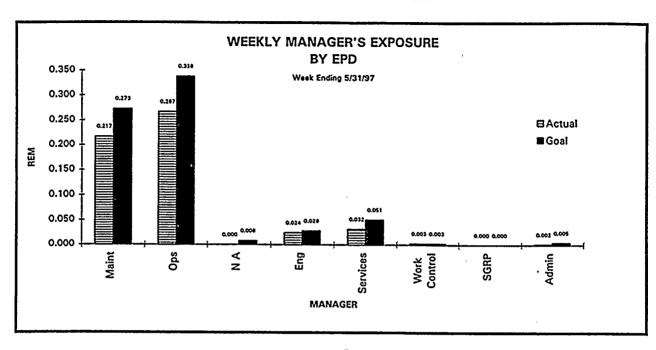


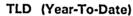


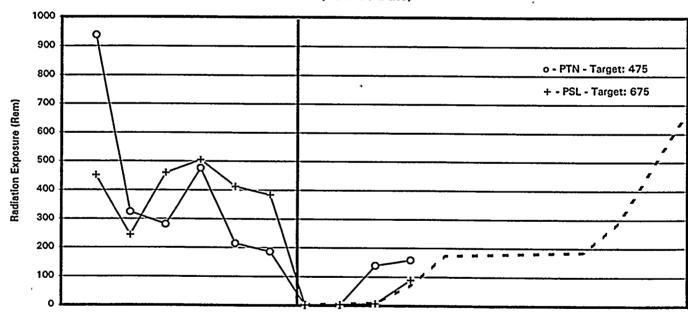
INDUSTRIAL SAFETY ACCIDENT RATE



RADIATION EXPOSURE





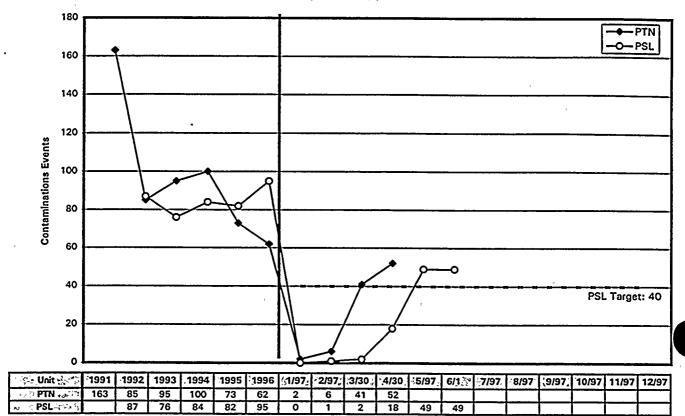


Unit	1991	1992	1993	1994	1995	1996	1/97	2/97	3/97	4/97	5/97	6/97	7/97	8/97	9/97	10/97	11/97	12/97
PTN Y-T-D	938.0		281.8															
PSL Y-T-D	451.3	244.5	459.9	504.7	412.8	384.6	2.3	4.4	7.1	89.8								

Providers: (PTN) John Lindsay 246-6548 (PSL) Hank Buchanan 467-7300

PERSONNEL CONTAMINATION EVENTS

(Year-To-Date)



Data Providers: (PTN) John Lindsay 286-6545 (PSL) Hank Buchanan 467-7300



WORK CONTROL

Chuck Wood

ST. LUCIE UNIT 2 1997 OUTAGE GOALS

OUTAGE PERFORMANCE INDICATOR	ACTUALS	GOAL
NUCLEAR SAFETY PROBLEMS	0	0
PERSONNEL SAFETY - LOST TIME ACCIDENTS	1	O
DOCTOR CASE INJURIES	1	6
MEET OR BEAT THE OUTAGE - SCHEDULE DURATION	41	42
MEET OR BEAT THE OUTAGE - BUDGET	\$27,781,000	\$32,497,216*
PERSONNEL EXPOSURE (ManREM) .	167	181
PERSONNEL CONTAMINATIONS (ANY CONTAMINATION RESULTING IN A SKIN DOSE)	4	10
CONTAMINATED FLOOR SPACE WITHIN 30 DAYS POST OUTAGE	0**	0
WASTE GENERATED (CUBIC FEET)	4440	6500
OUTAGE RELATED SIGNIFICANT CONDITION REPORTS	9	12

^{*} Original "As Budgeted"
Outage Dollars = \$28,023,000

^{**} as of 6/9/97

St. Lucie Unit 2 Spring '97 Refueling Outage OUTAGE ACCOMPLISHMENTS

- 12 Major Design Modifications
- 25 Minor Design Modifications
- 9 Other Emergent Modifications
- Major Tasks and Projects

Emergency Diesel Generator Inspections
Main Generator Rotor-out Inspection
2B Main Steam Isolation Valve Overhaul
Main Feedwater Isolation Valve Actuator Overhaul
Quick Loc Modification to ICI Flanges
Feedwater Flow Venturis-Clean/Repair/LEFM Calibration

• 1685 Work Orders Originally Scheduled

1955 Work Orders Worked.

Preventative Maintenance Work Orders 778
Corrective, Projects, Support, etc. 999

Component Maintenance Performed In SL2-10

ELECTRICAL

	Breakers/Switchgear	61
	Motors	46
	MOV PMs	68
VAI	LVES AND WELDING	
	Valves Repacked	134
	Valves Overhauled	44
	MOV PMs	17
	VOTES Tests	21
	Safety Relief Valves	42
	Air Operated Valves	87
,	Check Valves	55
	Valves Replaced	68
'RO?	TATING EQUIPMENT	
	Pumps (O/H or Replaced)	47
	Fans (O/H or Replaced)	24

SL2-10 Scheduled vs. Actual Duration

,	Scheduled	l Actual
RCS Cooldown (NOP/NOT to Mode 4)	9	10
RCS Drain Down and Reactor Disassembly	100	73
Steam Generators ECT and Plugging	432	312
2A Emergency Diesel Generator	217	269
Core Offload	76	90
Primary Valve Work (Freeze Seals)	198	147
Core Reload	76	103
2B Emergency Diesel Generator	226	204
B Train ICW System Out of Service	331	370
Reactor Reassembly	133	113
Engineered Safety Features Testing	36	30
RCS Heatup (Mode 4 to NOP/NOT)	55	62
Turbine/Generator Work	858	914

ST. LUCIE UNIT 2 1997 OUTAGE

OPERATOR WORK AROUNDS WORKED DURING SL2-10

"A PROBLEM THAT IMPEDES AN OPERATOR FROM PERFORMING DUTIES WITHIN APPROVED PROCEDURES OR IN ACCORDANCE WITH THE INTENDED DESIGN"

PRIORITY	OWA TRACKING#	EQUIP ID#	DEFICIENCIES	OPER ACTIONS REQ'D	PROPOSED RESOLUTION	RESOLUTION STATUS
А	297-002	PRESSURIZER CODE SAFETIES V1200/1/2	VALVES LEAK BY	OPERATE AT REDUCED PRESSURES	IMPLEMENT PCM 96-139	ALLOWED RCS OP PRESS INCREASE TO 2250 - INCREASED DNB MARGIN
В	296-004\	PCV-08-870 GLAND SEAL REGULATOR	REGULATOR DOES NOT	MANUALLY ADJUST PRESSURE OR USE BYPASS	START 11/1/96 & BE	VALVE WORKS IN AUTO, LOCAL MANUAL PRESS CONTROL NO LONGER REQUIRED
В		REACTOR COOLANT GAS VENT SYSTEM ALARM	SYSTEM VALVES LEAK BY - HIGH PRESS ALARM REVERSED	MONITOR SYSTEM	IRCGVS VALVES RCM 2082	RESTORED SECOND RCS PRESS BOUNDARY ISOLATION
В	· 297-003	TCV-13-8 GENERATOR EXCITER COOLER	ERRATIC CONTROL	OPERATE IN MANUAL ON BYPASS	REPAIR DURING OUTAGE	VALVE WORKS IN AUTO, LOCAL MANUAL CONTROL NO LONGER REQUIRED
В		CCW RELIEF VALVES SR-14350 SR-14359	IGVEELA/DELIEFG LIEL		IMPLEMENT PCM (INSTALL ORIFICE ON HCV-14-8A) I&C VLV	ELIMINATES CHALLENGING OPERATORS WITH POTENTIAL CCW INVENTORY LOSS WHEN CLOSING VALVE

ST. LUCIE UNIT 2 OUTAGE ISSUES

Engineered Safety Features (ESF) Testing

- Scheduled Duration 36
 - Actual Duration 30
- Tested one train at a time so that Shutdown Cooling Flow was maintained.
- Only one significant failure: 2A LPSI Pump
- Originally scheduled to be performed at the beginning. 2A LPSI pump failure required moving test to the end of the outage.
- No failures during testing at the end of the outage.
- Completely rewritten procedure worked well during first time use. Procedure throughly tested on Simulator during development.

Containment Sump Screens

- Condition discovered late in outage during sump inspection for Containment close-out.
- Openings found in screens around A and B sumps larger than described in FSAR.
- Screen patches applied over some openings, others covered with plate.
- 35 hours of Critical Path impact.

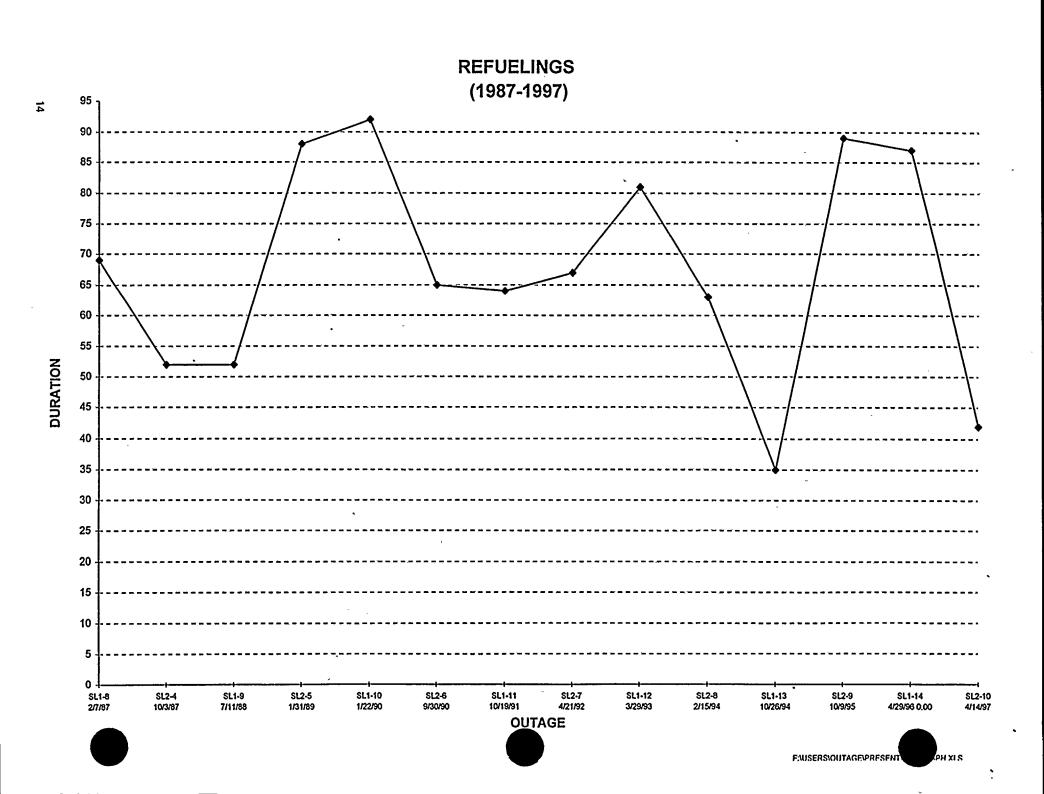
ST. LUCIE UNIT 2 OUTAGE ISSUES (cont'd)

Broken Incore Instruments

- Detectors broke during removal, but not immediately identified.
- CIS actuation when UGS raised for removal from vessel.
- 3 ICI pieces remained in UGS. One was extracted, the other two pushed to bottom and positions abandoned.
- Total of five broken detectors discovered.

Clearance Problems

- Several clearance errors (DC bus bkr, CWP, EDG oil pump) resulted in outage stand down to implement corrective actions.
- Major system clearances (i.e. RCS, Main Steam, Condensate) tagged too many components unnecessarily which caused major effort for boundary modification.
- Too many hoses installed on drains and vents that served no function.
- Clearances did not support work as scheduled. Components to be worked had clearance tags installed and required modification.



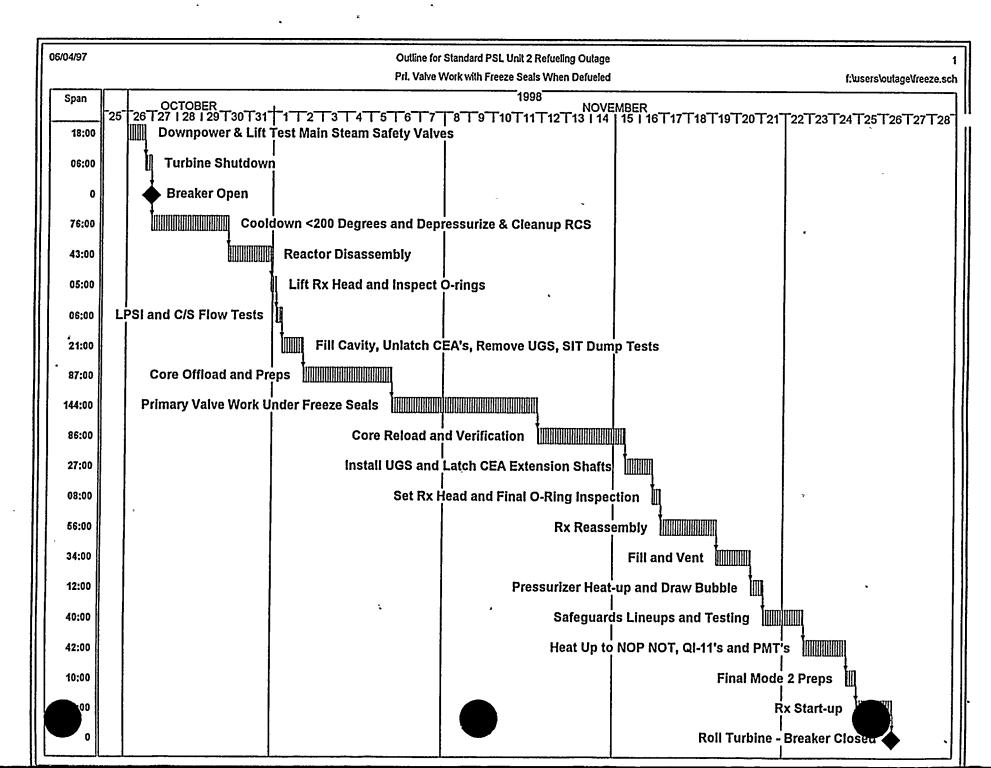
ST. LUCIE STANDARD OUTAGE

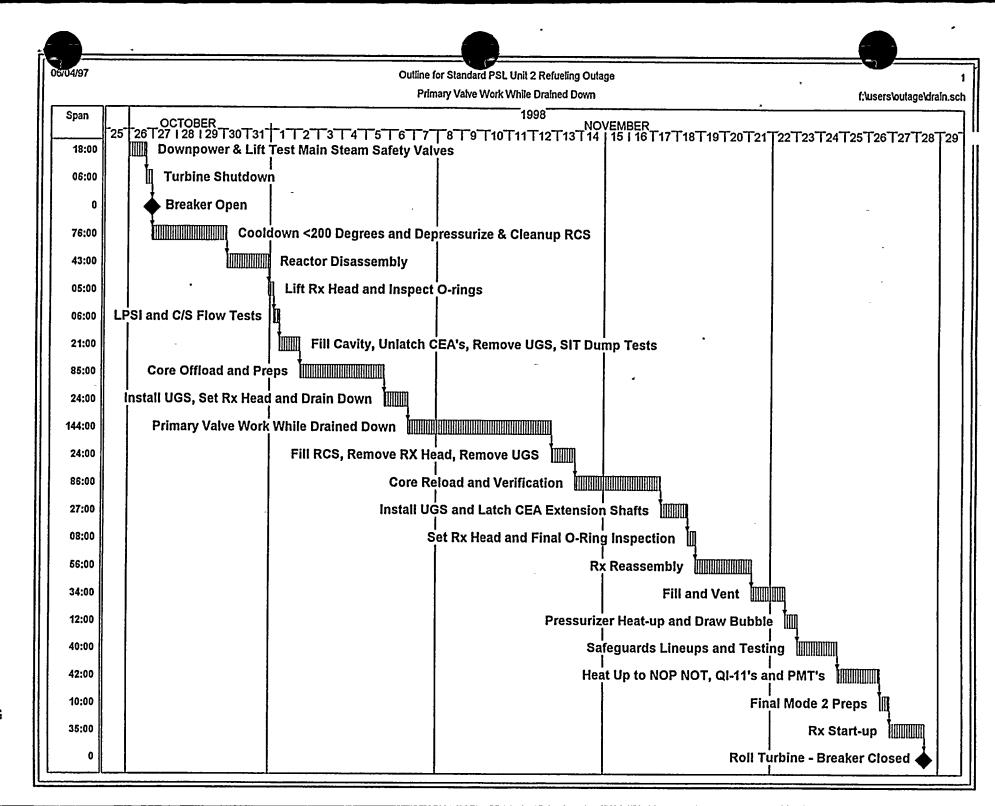
ASSUMPTIONS

- * Fuel shuffle not practical due to dependance on freeze seals for RCS boundary valve work
- * 100% ECT behind nozzle dams
- * No modifications considered that would impact critical path
- * No major non routine exams or tests included (ILRT, RX)
- * Six day work window with fuel off-loaded
- * 24 hour duration RCS clean up

Schedule One - RCS work defueled behind freeze seals 31 days

Schedule Two - RCS work defueled and RCS drained 33 days





FUTURE OUTAGE PERFORMANCE IMPROVEMENTS

- Improve Administrative Controls for Containment Entries After Containment Integrity is Established
- Improve Ramp Up and Inprocessing for Temporaries and Contractors
- Set Earlier Date of Discovery
- System Work Window Management
 - Better Definition of System Windows in Schedule
 - Select System Work Window Managers
 - Adhere to System Windows
- Increase Planning Horizon for Future Outages
 - Set Earlier Freeze Date for PCMs and Major Projects
- Reduced Outage Duration Initiatives
 - Refueling Equipment Upgrades for More Rapid Fuel Bundle Transit Times
 - Piping Modifications to Allow Higher Pressure Operation of Shutdown Cooling Purification
 - Operational RCS Heatup Durations

OPERATIONS

Hugh Johnson



STATUS OF NWE DOWN RELIEF TO RCO

- ▶ 27 SNPOs have been Fire Brigade Leader trained
- ► All procedure changes necessary to facilitate shift operation without NWE approved and on street as of 6/10/97.
- ▶ 3 NWEs have received required simulator training. Other 3 will receive training this weekend.
- All NWEs still require 40 hours of on-shift familiarization training prior to filling in as RCO.

Unit 2 Outage

Strengths:

Conservative plant operation

Support of the outage schedule

Conservative reactivity management

No lost time injuries

Control of material to reduce waste (screen material, wood reduction for scaffolding)

Decon efforts prior to and after working

Areas of Improvement:

Fuel element placement on the pins

S/G Wet Layup

EOOS Computer program/PMT Status

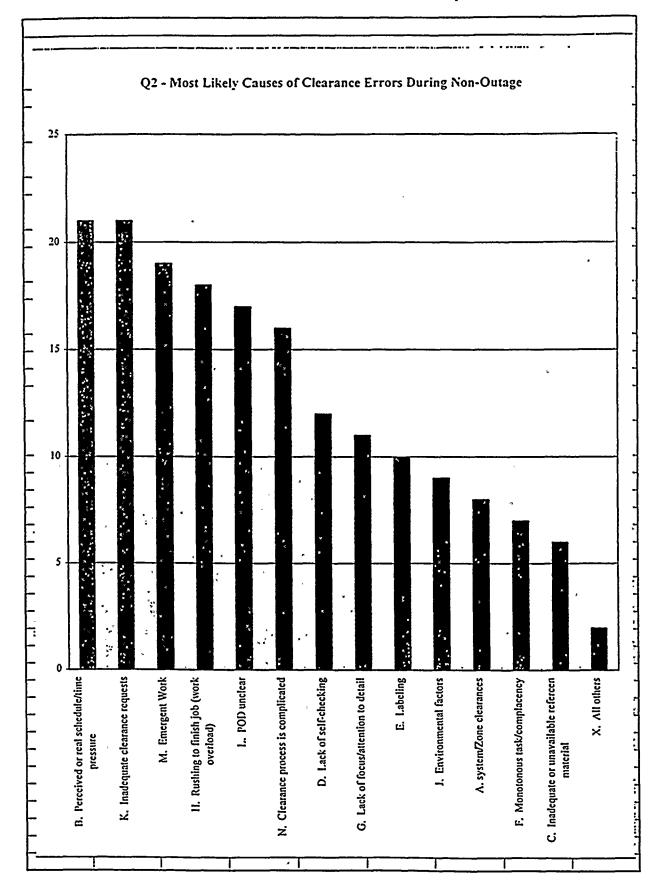
RCS cleanup coordination and criteria

The clearance process

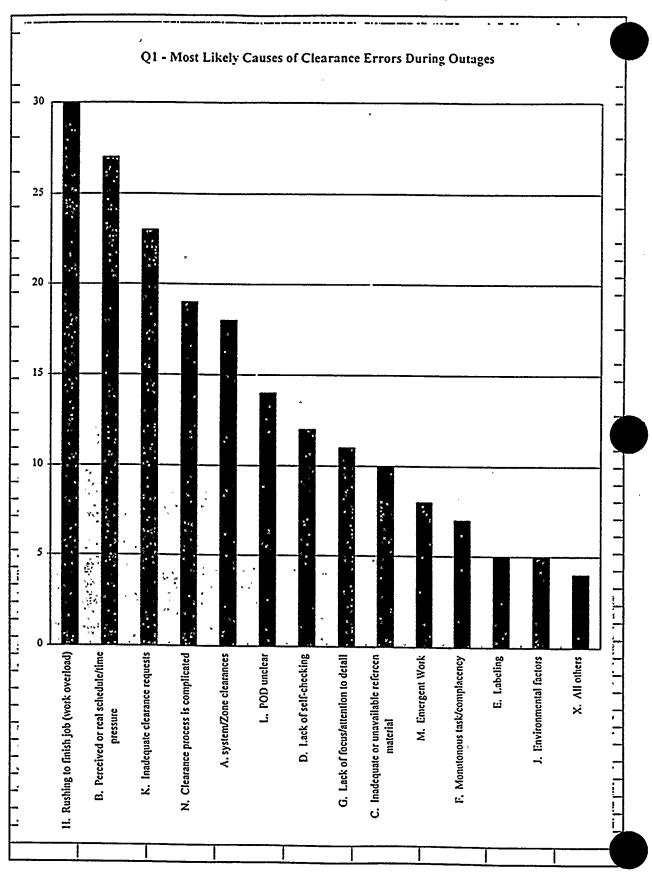
Administrative readiness: (writing clearances, procedure changes)

Need full time ALARA coordinators

Attachment E
Results of Clearance Team Survey



Attachment E
Results of Clearance Team Survey



Clearance Order Events

Process Weaknesses

- Planning and scheduling must allow sufficient time for the maintenance departments and Operations to plan their work.
- The Operations section of the Plan of the Day should be man-loaded to assure that resources are sufficient.
- The use of large clearances and the use of Release for Test and Boundary Modifications can be made easier by assigning specific clearances tags to the specific work orders listed on the clearance.
- Establish a section in the POD that captures all required activities for Operations, such as surveillances, clearances and support.

Training

- All personnel involved in the clearance process must be totally familiar with the different aspects of the process.
- Up-relieving personnel must be given the same training. Establish minimum OJT requirements that must be completed prior to up-relieving.
- Planners and schedulers should be given systems training, to facilitate the writing of work packages and clearance requests. This knowledge is critical for recommending clearance boundaries.
- Provide annual requalification training to all personnel involved in the clearance process.

Reference Materials

- Piping and Instrumentation Drawings are used extensively in the clearance process. However, the current size of the drawings does not allow for easy use in the field or wide spread distribution in the plant.
- Control Wiring Diagrams do not always reflect the wiring tag in the field and Operations is often relying on maintenance personnel to show them the proper lifted leads to tag.
- Improve the computer program for tracking clearance order control forms, to allow it to segregate jobs on clearance control forms by discipline.

Operations Staffing

- The Operations Section of the Plan of the Day should be man-loaded.
- Operations management has undertaken initiatives to address the licensed operator shortage.

Demand for Time

- Use of the appropriate Chain of Command during high level activities such as Critical Pat jobs, rather than direct calls to the Clearance Center and Control Rooms, will help reduce distractions.
- Operations on-shift management must increase the time spent in the field, observing the clearance process and assuring that expectations are being met.



MAINTENANCE

Joe Marchese

MAINTENANCE

SUMMARY:

The maintenance report will focus on the past refueling outage from a maintenance self assessment/critique. This report will list the strengths, weakness, and lessons learned, only a few will be discussed in detail. There were nine(9)strengths and thirty-two(32) weaknesses identified. Corrective actions for these weaknesses are also listed. In reality we were successful this outage however we're not winning because we still have poor programs, ownership and dedication at many levels. We don't boldly explore the best ways to do business because we can't break thru the barriers like others facilities are doing or have done. We are occupied by things other than our core business.

STRENGTHS:

The following were considered strengths/good practices:

- 1. SCAFFOLDING PROGRAM/USE OF WOOD IN RCA/RCB Staging of materials at ramp and the wood minimization in RCA/RCB.
- 2. CTMT COORDINATORS
- 3. CLEARANCE CONTROLLERS
- 4. NMM/STORES SUPPORT (PARTS AND MATERIAL AVAILABILITY)
- 5. IC OUTAGE ORGANIZATION (ABILITY TO HANDLE WORK)
 Solid supervision on all shifts, minimum use of temps, relied more on temps as support (UT1&2's
- 6. WELDING PROGRAM
 Quality, ability to stay ahead, increase work scope
- 7. ROTATING GROUP (STAYED AHEAD)
- 8. REACTOR REASSEMBLY
- 9. 30 MINUTE RULE

- 1. TOO HEAVY PLANT RELIANCE ON THE USE OF FREEZE SEALS Resulted in excessive overtime, personnel injuries, and high cost to plant
- 2. FME/CAVITY MONITOR PROGRAMS

 No single program ownership resulted in unclear standards/practices.
- 3. REWORK IN VALVE AREA EXCESSIVE
 Training, supervision, expectations, looking ahead
- 4. MECH TEMPS-NUMBER, QUALITY, DEDICATION, OWNERSHIP Beyond core temps no ownership, no dedication, not wanted or accepted by bargaining unit. Local craft had more ownership in job.
- 5. INEXPERIENCED LEADERSHIP IN MECH (SUPV/FOREMAN)
- 6. WORKER OWNERSHIP/JOB DEDICATION
- 7. RAMP CREW-KNOWLEDGE, MOTIVATION, WORK EXPERIENCE
- 8. INCORE REMOVAL JOB PLANNING/IMPLEMENTATION
- 9. HOSE PROGRAM-COSTLY, NOT WELL PLANNED, INFLEXIBLE POLICY
 We hang hoses for everything, do not walk down to see if needed, just issue paper to hang
- 10. MAJOR PUMP OVERHAULS NOT COST EFFECTIVE AT SITE

- 11. QUALITY REVIEWS INADEQUATE ON INCORE REMOVAL
- 12. OVERTIME NOT USED WISELY, PERSONNEL SAFETY ISSUES
- 13. TOOL ROOM STAFFING NOT TIMELY, BROUGHT IN TOO LATE
- 14. INSULATION/LAGGING TOO EXPENSIVE NEED ALTERNATE SOLUTION
- 15. HY-TORQUE PROGRAM SELF IMPOSED CONTROLS TOO DIFFICULT TO COMPLY WITH DURING OUTAGES
- 16. DRAIN/VENT VALVE LEAKS UNECONOMICAL APPROACH PRACTICED
- 17. HP PROGRAM/PRACTICE FOR PERSONNEL LEVEL, CONSISTENCY
- 18. E/M RESOURCE STAFFING INADEQUATE/OVERTIME
- 19. TURNOVERS/COORDINATION NOT AS EXPECTED/REQUIRED Resulted in (26) unsatisfactory performance issues
- 20. PERSONNEL SAFETY PERFORMANCE BELOW EXPECTATIONS
- 21. VALVE ORGANIZATION SIGNIFICANT PROBLEM
- 22. CLEARANCE PROGRAM INSUFFICIENT UNDERSTANDING Require further changes/training/understanding.

- 23. EOOS LOG CUMBERSOME NOT FULLY FUNCTIONAL
 Time and process caused delays and loss of productivity
- 24. CONSTANT MANAGEMENT CHANGE PRIORITIES/DIRECTION/
 JOBS
 This was understood however it was identified in
 several critiques as a contributing factor in
 substandard performance issues, turnovers and lack
 of looking ahead.
- 25. SAFEGUARDS TESTING UP-FRONT FAILURE
- 26. INADEQUATE PRE-OUTAGES PWO REVIEWS/WALKDOWNS PWO's not available and personnel not assigned
- 27. SCAFFOLDING NOT IDENTIFIED UP-FRONT
 Planning/production/ISI didn't look ahead.
 Excessively high number of emergent scaffolds required
- 28. MISUSE OF CRs
- 29. HIGHER DOSE RATES PERSONNEL EXPOSURE
- 30. INSUFFICIENT TOOLING JOB DELAYS
- 31. ISI COORDINATION .
 Inconsistent direction
- 32. OUTAGE SERVICE AIR SYSTEM
 Compressors kept tripping-job delays

- 33. M&TE TOOLING TORQUE WRENCHES/TEST GAUGES
 Increased exposure and job delays
 - 34. LIGHTING/POWER LOSSES DUE TO SAFEGUARDS TESTING Caught personnel unprepared
 - 35. PLANT GAITRONICS & TELEPHONE UNRELIABLE Need proper maintenance
 - 36. TP&L WORK AREA
 No place to prep TP&L

LESSONS LEARNED/CORRECTIVE ACTIONS:

- 1. Develop method to set UGS and Rx Head
- 2. Assign program owner, revise program
- 3. Quality of personnel(temps, supervision)

 Dedicate personnel to look ahead

 Ensure expectations/requirements are known
- 4. Limit number of mech temps
 Restrict uprelieving, plant's best interest only
- 5. More selective in supervision selection
- 6. Explore alternate ways of getting work performed
- 7. Develop dedicated ramp team with inside or outside resources (SGRP will do ramp in SL1-15)
- 8. Capture lessons learned and incorporate INTO SL1-15
- 9. Adopt more realistic approach based on walkdowns Build hose data base for drain/vent hoses
- 10. Negotiate long term service contracts for major pump overhauls at outside facilities(PTN)
- 11. Ensure feedback is forwarded to QA
- 12. Plan better, this was known/recognized pre-outage.
- 13. Bring in tool room personnel(UT2) one week prior to rolling into outage shifts
- 14. Explore alternate ways to perform insulation/lagging
- 15. Revise program
- 16. Develop housekeeping vs maintenance leak program criteria still to be zero leaks
- 17. Replicate PTN program
- 18. Don't bury head in sand
- 19. Develop strict turnover requirements

LESSONS LEARNED/CORRECTIVE ACTIONS:

(Continued)

- 20. Don't hire personnel with previous record of unsafe work practices/change scaffold material/resist mid outage shift changes
- 21. Selection of supervision, supervision ratios, number of temps
- 22. Task team formed to identify and resolve issues 23. Replicate PTN'S EOOS log and computerized signoffs
- 24. More pre-outage job planning/walkdowns and preparation needed
- 25. Do safeguards at end of outage (recommendation)
- 26. Get PWO'S out and dedicate production people to walkdown jobs preoutage
- 27. Enforce preoutage walkdowns by all groups and scaffolds requests (including planners)
- 28. Culture of the site
- 29. HP/Site Management aware of issues
- 30. Under evaluation by tooling supervisor

ENGINEERING

Carl Bible

PSL UNIT 2 CYCLE 10 REFUELING OUTAGE CRITIQUE - ENGINEERING

Successes:

- Venturi cleaning MW gain
- New Integrated Safeguards procedure
- Flow accelerated Corrosion CR's issued in 3 days
- Handled a large number of emergent issues

Items Requiring Improvement:

- Use of Condition Report dispositions to perform field work versus other engineering documents
- Continuing problem with software changes
 - a) Inadequate PMT/V&V
 - b) Refueling Machine PLC
- Longterm plan for the Refueling Machine PLC
- Better planning on valve inspections and testing up-front, i.e. review previous Votes testing, LLRTs, etc.
- Resources and running of crews for scaffolding/insulation work need to clearly be in Maintenance's house not Engineering's

Items Requiring Improvement (cont):

- A number of issues that should have been well defined prior to the outage emerged as issues:
 - 2B1 RCP seal
 - SIT dump test w/UGS in
 - Connection of Containment A/C
 - Refueling Machine setpoints Camera deletion
 - ICW new slip-on flanges thicker then original
 - Various PMAI issues
 - MSIV indications
 - PORV strain gauge removal
- A number of emergent issues were not handled well up-front:
 - RCP oil collection modification
 - MI cable support issue
 - Containment Sump
 - 2A1 EDG electric priming pump
 - DC Tie breaker testing

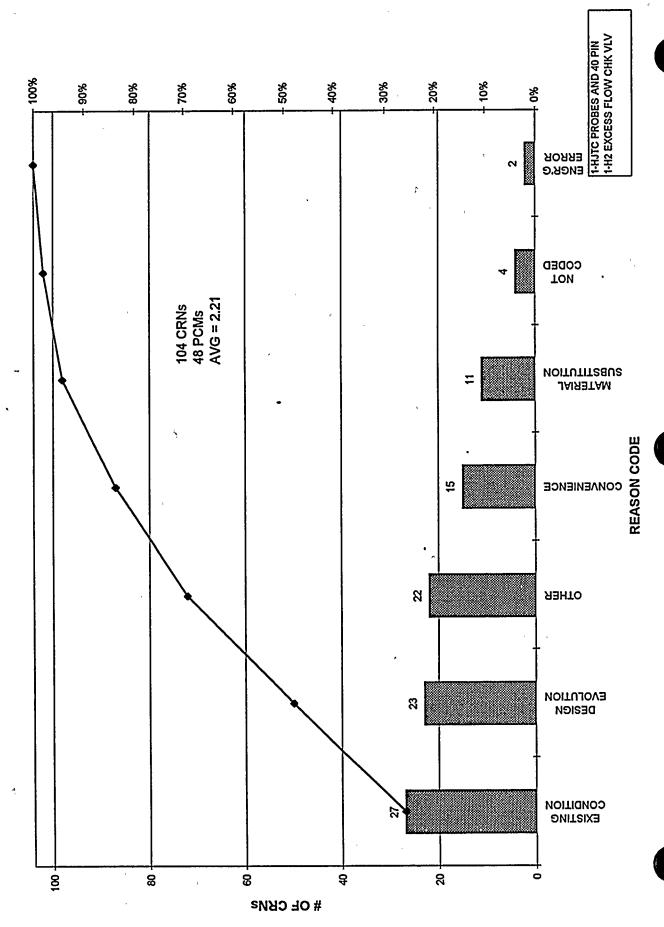
Items Requiring Improvement (cont):

- POD scheduling of Engineering activities
 - FAC
 - Snubber Inspections
 - ISI/IST
 - Maintenance manpower support and scaffolding coordination
 - Need to verify all logic ties
 - Need file for all engineering POD items/better descriptions
- Condition Reports were excessive (197)
 Need to stratify for efficiency
 improvements
- Engineering Design Errors
 - Hydrogen excess flow checkvalve
 - DDPS calometric change/FW venturi calc's
 - CEDM duct flange leakage, engineering removed margin
- PC/M and procedures for full core offload. Generically need to review significant / new system alignments and tests
- New MSSV procedure not sufficiently "walked through";

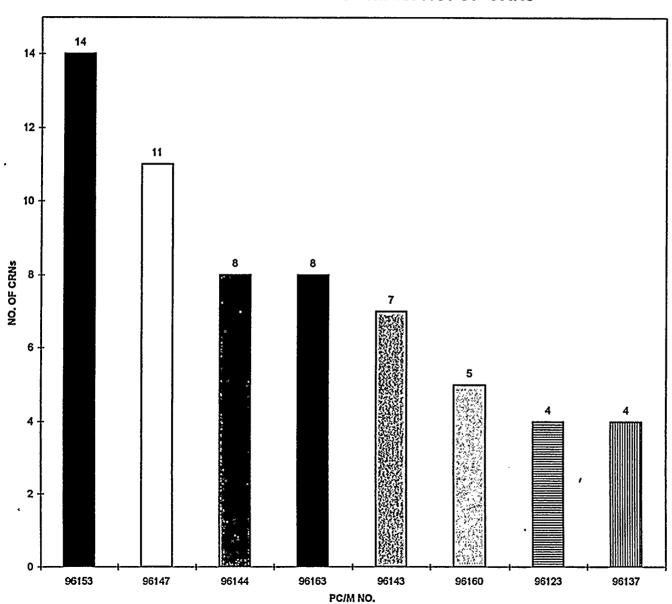
Items Requiring Improvement (cont):

- Review valve LLRT history to determine where softseats could be installed
- Control of Technical Specification surveillances (central database)
- SCE readiness for mode 4 walkdown determine criteria/value added
- CSI/FAC coordination
- Training on FAC minimum wall issues
- Better understanding of inspections such as Anchor Darling check valves needed
- Engineering readiness and ability to "Look Ahead" at upcoming tests (i.e. meet initial conditions, test equipment readiness, etc.)

SL2-10 OUTAGE CRNs



SL2-10 OUTAGE PC/M vs. NO. OF CRNs



96153 QUICKLOC FLANGE 96147 FW FLOW VENTURI 96144 HJTC PROBE/40 PIN 96163 T-LAG/RAD. SHLD 96143 T-LAG COND. REROUTE 96160 RCGVS SOL. 96123 AFWP WARMUP LINE 96137 EDG RELAYS 

SERVICES

Dennis Fadden

Prepare for Operations Training Accreditation Renewal

✓ Performed external evaluation complete 2/28/97

√ Conducted self-evaluation complete 3/28/97

✓ Developed draft Accreditation complete 4/30/97
Self-Evaluation Report (ASER)

✓ Submitted ASER complete 5/08/97

✓ Conducted follow-up assessment complete 5/23/97 on unseen areas

√ Collected and shipped materials to INPO complete 5/30/97

→ Implementing corrective actions underway

→ Accreditation Team Visit 6/23/97 through 6/27/97

→ Perform Mock Board 9/02/97

→ National Accreditation Board Presentation 9/17/97

Enhance Training Programs and Processes

On-the-Job Training (OJT) and Evaluation

- ✓ Strengthened processes per ACAD and industry best practices
- ✓ Increased oversight of training and evaluations

Student and Management Feedback Process

- ✓ Streamlined feedback and analysis activities
- → Emphasizing responsibilities to managers and students (2 training strengths + 2 improvements)

Non-Licensed Operator Initial Training

- ✓ Redesigned watchstation final qualification packages
- ✓ Obtained management support of defined training expectations

Upgrade Non-Technical Training Programs

Maintenance SupervisorTraining

- ✓ Verified current supervisors' qualifications to ACAD responsibilities and accountabilities
- ✓ Designed professional development matrix

Shift Supervisor Training

- ✓ Revised qualification and mentoring requirements
- → Preparing personal professional development plans for incumbent shift supervisors

Engineering Support Personnel Training

- √ Redesigned Engineering qualification cards
- → Conducting new engineer training with department
- → Increasing simulator training time

Eliminate Backlogs

Eliminate TSAR Backlog

- Reduced by 12% 5/02/97 through 06/06/97 (171/1400)
- Reduced potential risk-significant needs analyses by 65% as of 06/06/97 (296/459)

Enhance Instructor Continuing Training

- ✓ Established Instructor Training Review Committee
- Implemented joint simulator instructor continuing training with PTN
- Implementing Annual Training Plan to address identified instructor needs

Implement Instrument & Control Training

- Providing systems training requested by customer

Increase Level of Effort in Benchmarking

→ Improving OJT/TPE, management training, other enhancements based on trips to McGuire, SSNTA, and INPO

Improve Line Management Ownership of St. Lucie Training

- ✓ Emphasized industry expectations
- ✓ Initiated line manager approval of training materials and session presentation
- ✓ Trained NPSs and other managers in observation skills and Systematic Approach to Training
- ✓ Enhanced effectiveness of PTABs and TRCs through meeting chairmanship by plant department head and participation by job incumbent
- √ Established line management ownership indicator
- → Establishing maintenance manager approval for job qualifications



MATERIALS MANAGEMENT

Gil Boissy



	CRITIQUE ITEM	WORK GROUP	SUGGESTED RESOLUTION
	WEAKNESSES		
1	Material request for Section XI, were not identified as a Section XI activity by the user at the issue counter (at the time of issue). NMM must be aware material is for a Section XI activity in order to issue the reserved/tagged prescreened material	All Plant Maint. Groups	The work order packages should be in the possession of the individual requesting the material from the issue counter. The work order clearly identifies the Section XI requirement applies and can be easily conveyed to NMM.
2	Lack of experienced NMM personnel available to adequately support Dry Storage Building activities.	NMM WHSE	Beginning the week of 6/7 a training program has been implemented to expose less experienced NMM personnel in the actual responsibilities and administrative activities associated with NMM Dry Storage Building support.
3	Shipping crates for the Main Steam Safety Valves are inadequate for handling and/or storage upon return from vendor.	Valve Group	Prefabricated metal shipping crates should be utilized to ensure safe handling and material integrity.
4	·		
5			

	CRITIQUE ITEM	WORK GROUP	SUGGESTED RESOLUTION
	STRENGTHS		
	Implementation of the Parts/Materials List, and incorporating the list in the Outage POD. This report was the main resource and a valuable tool for NMM Outage Coordinators to represent NMM accountabilities during the outage meetings.	W/C, NMM	This new report has now become part of daily business with an updated report incorporated with the daily POD.
1	Teamwork. The NMM Department worked as team from the point of outage prep, to the end of the schedule. Assistance was lent from each area, and shifted to the group that needed the support during the periods that were most critical.	All NMM Groups	Continue to focus on shifting manpower for pre-outage activities and manpower support at the issue counter, receiving and back shifts during outage.
	2.6 million dollars of inventory staged at pre-determined plant controlled locations prior to the start of work activities, allowed for better management of NMM manpower resources and reduced plant time at the issue counter waiting for material.	NMM WHSE	Continue and enhance the material staging program for future outages. Limited scope staging activities have now become part of daily business.
4	NMM tracking the return of repair/reconditioned material off site, provided the necessary reporting to monitor and report on due dates, for material delivery back to the site.	NMM MAG	Tracking and visibility of repairs/refurbished material is now part of daily business.



NMM SL2-10 OUTAGE CRITIQUE

6/10/97

Use of temporary employees for material issue and retrieval of material from remote locations allowed NMM employees to remain in critical support roles as required.	NMM WHSE	Utilize temporary employees for future outages.
--	----------	---



BUSINESS SYSTEMS

Rick Heroux

PSL Business Systems Outage Performance

- Strengths
 - Weekly cost forecasts were more accurate than past
 - MIS maintained LANS at >98% availability
 - Deployment of computers to outage support personnel
 - Decentralized payroll clerks
 worked well

PSL Business Systems Outage Performance

- Weaknesses
 - Too many 'Base' Budget problems were solved by cutting projects
 - Improve overtime Tracking and Control
 - Improve Contractor Reporting
 - Improve Temporary EmployeePayroll Processing

PSL Outage Cost Performance

• Budget \$28,023

• Current Forecast \$27,781

• Forecast Underrun \$ 242

1998 BUDGET

OUTAGE

\$19,490,000

NON-OUTAGE PAYROLL

\$41,650,000

OTHER NON-OUTAGE

\$29,241,000

NON-DISTRIBUTED FUNDS (ALL PROJECTS, ALL CONTINGENCY)

\$ 5,119,000

TOTAL

\$95,500,000



STEAM GENERATOR REPLACEMENT PROJECT

Dick Daley

STEAM GENERATOR REPLACEMENT PROJECT

SGRP Overview

- RSGs are here in storage inside protected area with N₂ Blanket on primary and secondary sides.
- SGT staff in place.
 - Documents (EPs, WPs, DPs & QEPs) being prepared and approved; to be complete by August 1, 1997.
- Detail work schedules being developed integrating with plant activities.
- FPL staff being assembled combination FPL and Contractor 75%.
- Major pieces of handling equipment (TLD.TG, HTS) are coming from Netherlands in late August or early September. TLD will be assembled in South Forty for load testing and equipment checkouts.
- Start pouring concrete for TG base in mid-August.
- Plans for OSG disposal are being developed.
 - Contract with Chem Nuclear in place.
 - Submittal to DOT in progress.



LICENSING

Ed Weinkam

ST. LUCIE LICENSING

1997 NRC Enforcement Status

- In excess of an estimated 1700 NRC Inspection hours incurred for 1997
 - 1997 Violation Status
 - Violations = 5 Received
 - NIR 97-04 included two violations
 - Excessive Use of Overtime
 - Clearance Errors
 - Non-Cited Violations = 8 Received

Recently Completed Inspections and Visits

- Inservice Inspection Program Implementation
- Thermo-Lag Modifications (NRR)
- Sea Turtle Biological Opinion (NRR/NMFS)
- Engineering Open Items
- Visiting Resident Inspectors Objectivity Visits
- SALP Management Meeting
- NRR "Associate Director for Projects" Site Visit

ST. LUCIE LICENSING

Inspections and Meetings through September 1997

Licensed Operator Exams - Weeks of 6/2/97 and 6/16/97

Employee Concerns Program - Week of 6/9/97

Fitness For Duty Followup - 6/16/97 through 6/18/97

A/E Inspection: Open Issues - Week of 6/16/97

Bimonthly Status Meeting - 6/17/97

Steam Generator Replacement - Week of 7/7/97

Engineering Information Meeting- 7/15/97

Fire Protection - Thermo-lag Implementation - Week of 7/21/97

Maintenance - Week of 8/11/97

Effectiveness of Controls in Identifying, Resolving, and Preventing Problems: Corrective Action Review - Week of 8/18/97

Vehicle Barrier Implementation - 8/28/97 and 8/29/97

Steam Generator Replacement Heavy Lift - Week of 9/8/97

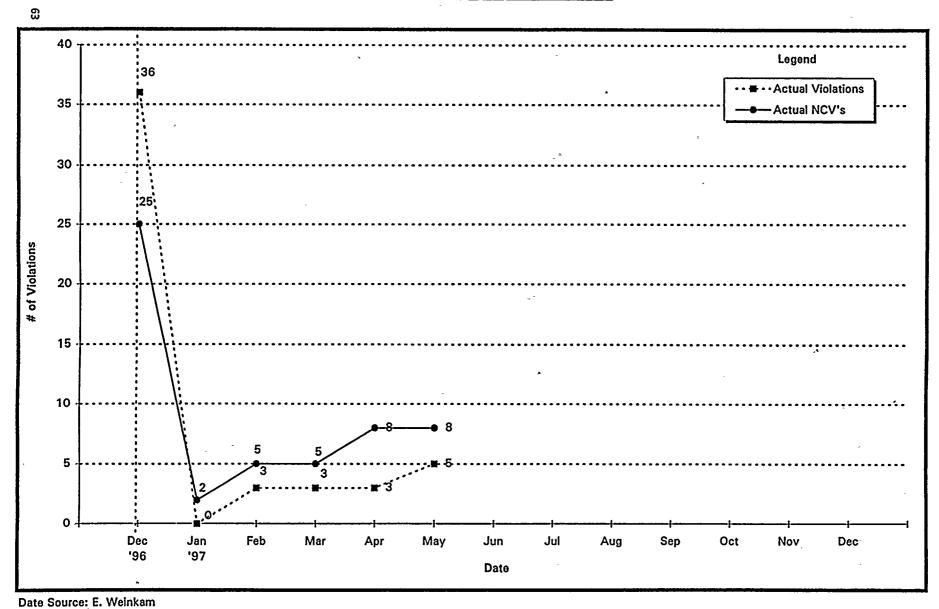
GL 89-10: MOV Program Closeout - Weeks of 9/15/97 and 9/22/97

ST. LUCIE LICENSING

Licensing Activities

- Significant Licensing Issues Resolved
 - Unit 1
 - Refueling Water Tank Bottom ASME Code
 Repair Approved as Relief Request
 - Small Break LOCA Reanalysis with 30% Steam Generator Tube Plugging
- Significant Licensing Issues Under NRR Review
 - Unit 1
 - Steam Generator Runtime Analysis Radiological Impacts Evaluation
 - Units 1 and 2
 - New Fuel Storage Areas Exemption from the Criticality Monitoring Requirements of 10 CFR §70.24
 - Incidental Take Permit Biological Opinion

NRC VIOLATIONS





QUALITY ASSURANCE

Wes Bladow

Quality Assurance

Audit Results:

- Primary Coolant Sources Outside Containment Audit
 - Improper maintenance of test records
 - Improper use of drawings
- Maintenance Functional Area Audit
 - Work Control Process Efficiency and Error Reduction
 - Minor Maintenance Program Implementation
 - Control of Parts
 - Safety Related Scaffold Approval Practices
- Document Control and Records
 - Improper storage of QA Records
- ODCM / PCP / Effluents Functional Area Audit
 - Control of Quality Related Items
 - Control of effluent process monitor set points
 - Calibration procedures for gaseous process monitors
 - Configuration control of liquid radiation monitor
 - Maintenance of effluent monitoring equipment
- Security and Safeguards Information Control Functional Area Audit
 - Hand geometry unit maintenance procedures
 - Security software verification practices
 - Security Department records
 - Inadequate Corrective action for access control deficiencies

Focus areas for Corrective Action Identified During the Unit 2 Outage:

- Configuration Management & PCM Implementation
 - Stop Work Order -PC/M 97011M "Structural and Valve Modification Associated with Removal/Reinstallation and Refurbishment of HCV \ 08-1B
 - ICI PCM Implementation
 - Core reload PC/M Implementation
 - CRN used to revise the feedwater flow venturi PC/M
 - Replacement of PZR Code Safeties without a 50.59 evaluation
- Freeze Seal Implementation Practices
- Software controls
 - PAR Programmable Controller
- Clearance process Implementation
- Continuing problems with FME controls

Overall Assessment:

- Marked improvement in Outage Management
- Excellent steam generator tube plugging by ABB-CENO
- Continuing problems with FME controls
- Continue to stress the need to follow procedures