

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos: 50-250, 50-251
License Nos: DPR-31, DPR-41

Report Nos: 50-250/99-03, 50-251/99-03

Licensee: Florida Power and Light Company

Facility: Turkey Point Nuclear Plant, Units 3 & 4

Location: 9760 S. W. 344 Street
Florida City, FL 33035

Dates: May 2 - June 12, 1999

Inspectors: C. Patterson, Senior Resident Inspector
R. Reyes, Resident Inspector
S. Rudisail, Project Engineer (Section E8.2)
N. Merriweather, Reactor Inspector (Section E8.2)

Approved by: L. Wert, Chief
Reactor Projects Branch 3
Division of Reactor Projects

Enclosure

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EXECUTIVE SUMMARY

Turkey Point Nuclear Plant, Units 3 & 4 NRC Inspection Report 50-250/99-03, 50-251/99-03

This integrated inspection included aspects of licensee operations, maintenance, engineering, and plant support. The report covers a 6-week period of resident inspection; in addition, it includes the results of a year 2000 readiness review.

Operations

- A Non-Cited Violation was identified for inadequate independent verification of locked valves. Several examples were identified in which workers failed to properly perform independent verification of locked valves (Section O1.2).

Maintenance

- Maintenance rule reports were detailed and thorough. Previous NRC comments concerning optimization of availability and reliability were appropriately addressed (Section M1.1).
- The maintenance activities on the diesel driven fire pump were well supported. The material condition of the pump was good (Section M2.1).

Engineering

- The licensee was aggressively pursuing corrective actions for slow nitrogen leakage into the high head safety injection system (Section E2.1).
- The Y2K checklist, per TI 2515/141, Review of Year 2000 (Y2K) Readiness of Computer Systems at Nuclear Power Plants, was completed. Overall, the Y2K project is about 99 percent completed for Category 1 and 2 items and the contingency plan is about 85 percent completed (Section E8.2).

Plant Support

- The licensee was pro-active in preparations for the hurricane season. Procedures were comprehensive for equipment protection, Operations, emergency preparedness, and recovery (Section P2.1).
- Monitors being used to observe areas as a Fire Protection compensatory measure were not properly labeled. The indicated camera viewing locations were not correct. Corrective actions included revision of procedures to prevent recurrence. Fire Protection commitments were being met (Section F1.1).
- The fire brigade responded satisfactorily during a fire drill in the cable spreading room (Section F4.1).

Report Details

Summary of Plant Status

Unit 3 operated continuously during this period and has been on-line since October 29, 1998. Power was reduced between May 8-9, 1999, for turbine valve testing and heat exchanger cleaning.

Unit 4 operated at full power this period and has been on-line since April 8, 1999.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (71707)

Using Inspection Procedure 71707, the inspectors conducted frequent reviews of ongoing plant operations. In general, the conduct of operations was professional and safety-conscious. Specific events and noteworthy observations are detailed in the sections below.

O1.2 Independent Verification of Locked Valves

a. Inspection Scope (71707)

The inspectors reviewed several issues regarding independent verification of locked valves.

b. Observations and Findings

On April 16, 1999, the inspectors identified that valve 4-70-362A, 4A Emergency Diesel Generator (EDG) Oil Storage Tank Sample Point, did not have the locking mechanism correctly installed. The steel wire was wrapped around the valve handle and the lock was locked, but the wire was not secured to prevent the valve handle from turning. The inspectors reviewed the same valve on the Unit 4B EDG and similarly found that the valve was not correctly locked. The licensee wrote condition report (CR) 99-0631 to address this issue. The licensee believed these valves were last manipulated during execution of surveillance 0-NCZP-022.1, Fuel Oil Inventory Data Collection, which was performed on March 28, 1999. The licensee could not locate the completed copy of the procedure. The inspectors discussed this issue with a chemistry supervisor. The supervisor recalled reviewing the completed surveillance procedure and the two valves had been signed off and independently verified as locked closed. Attachment 3 of 0-NCZP-022.1 requires independent verification that valves 4-70-362A and 4-70-362B are locked closed. The licensee addressed the lost completed procedure record in the condition report.



On April 29, 1999, the inspectors identified that valve 4-757C, RHR 'B' Heat Exchanger Bypass Header Isolation, was not locked. A chain and a steel wire lock were installed on the valve handle. However, the chain was not secured from moving. The licensee wrote CR 99-0685 to address this issue. The valve was last operated during startup after Unit 4 outage in the performance of procedure 4-OP-050, Residual Heat Removal System. Valve 4-757C had been signed off in the completed procedure as locked closed and independently verified.

In addition, the licensee had recently completed the scheduled surveillance procedure 0-OSP-205, Verification of Administratively Controlled Valves, Locks, and Switches. This procedure provides a periodic independent verification of the status of valves, locks, and switches. Attachment 3 of procedure OSP-205, which includes valve 4-757C, had been completed on April 24, 1999.

The inspectors noted that on April 6, 1999, the licensee had identified that valve SGWL-4-028, Sensing Line Root Valve, did not have a lock installed. The valve was required to be locked closed. The licensee wrote CR 99-0562 to address this issue. The valve had been replaced during the outage. Independent review of this issue by the inspectors indicated that after the valve had been replaced, equipment clearance #4-99-01-133-R of procedure ADM-212, In-Plant Equipment Clearance Orders, required valve SGWL-4-028 to be independently verified as locked closed. In addition, the following day during performance of the alignment verification procedure, 4-OSP-053.4, Containment Integrity Penetration Alignment Verification, the valve had been signed off as being locked closed. On the day following the independent verification of the clearance, the same operator signed the alignment verification confirming the valve was locked closed as required in procedure 4-OSP-053.4. However, the operator did not actually check the valve position or whether it was properly locked. He signed the alignment procedure based on his recollection that he had independently verified the previous day that the valve was locked closed. Operations management indicated that signing the surveillance procedure based on recollection of the valve position the previous day was not an acceptable practice. The licensee did not find any records indicating the valve had been manipulated after it had been independently verified locked closed on the clearance. The missing valve lock was not found.

As a result of these issues, the licensee initiated a station review of all locked valves using procedure 0-OSP-205. Six other examples were identified by the licensee which did not meet the requirements of procedure 0-OSP-205. No operability issues were identified and only one valve was found in the incorrect position. PIV-64, Fire Main Isolation valve, is a normally locked open valve. On May 2, 1999, the valve was found locked in the closed position. CR 99-0691 was written to address this issue. The licensee found that on March 30, 1999, during execution of procedure 0-OSP-016.30, Fire Main PIV Flowpath Test and Flush, a procedure step for PIV-64 had been signed as locked open. As of May 2, the independent verification had not been completed and the procedure was still being performed. Licensee management stated that the independent verification should have been performed in a more timely manner. The inspectors found that surveillance procedure 0-OSP-205, performed on April 24, 1999, had also verified that PIV-64 was locked open.



Licensee corrective actions to address the independent verification issues included revising procedure 0-OSP-205 by making separate sign offs for the valve position and for ensuring the locking mechanism is adequate. Operations Department Instruction, ODI-CO-018 Valve Manipulation Expectations, was reviewed and will be revised to address locking verification requirements and expectations. In a separate condition report (CR 99-629) which had been previously written to address unfavorable trends in the Operations error rate, the licensee was also addressing valve manipulation expectations. Valve manipulations were demonstrated by operators supervised by a Senior Reactor Operator to ensure they meet the expected standards. Several other initiatives were undertaken to address the unfavorable trend in operations.

Technical Specification 6.8.1 requires that written procedures shall be established, implemented, and maintained covering the activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, dated February 1978. Section 1.C of Regulatory Guide 1.33 specifies procedures for equipment control (e.g., locking and tagging). Independent verification requirements are specified in procedures 4-OP-050, Residual Heat Removal System; 0-NCZP-022.1, Fuel Oil Inventory Data Collection; and 0-ADM-212, In-Plant Equipment Clearance Orders. The licensee failed to properly implement these procedures as noted by the examples of inadequate independent verification described above. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This is identified as NCV 50-250, 251/99-03-01, Independent Verification Of Locked Valves. This violation is addressed in the licensee's corrective action program in the CRs described above.

c. Conclusions

A Non-Cited Violation was identified for inadequate independent verification of locked valves. Several examples were identified in which workers failed to properly perform independent verification of locked valves.

O2 Operational Status of Facilities and Equipment

O2.1 Direct Current Electrical System (71707)

On June 10, 1999, the inspectors walked down components of the electrical system. Each of the four safety battery rooms and spare battery room were inspected. The seismic mounting of the batteries, general cleanliness, electrolyte levels, and protective caps were found in good material condition. The operation and alignment of battery chargers and inverters were found satisfactory. No substantial concerns were identified.

O5 Operator Training and Qualification

O5.1 Simulator Observations (71707)

On June 8, 1999, the inspectors observed training activities on the control room simulator. A hurricane preparedness scenario was conducted that discussed the loss of meteorological instrumentation power, clogging of service water system, battery loading,

and cooling water heat loads. Each operating crew was scheduled for this training. Additional training was observed in performance of job performance measures and a loss of coolant accident scenario. Instructor discussions were good and timely. Minor inconsistencies in three-way communications were critiqued by the instructor.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Periodic Assessment

a. Inspection Scope (62707)

The inspectors reviewed the maintenance rule periodic assessment dated April 8, 1999, for Unit 3 cycle of operations April 16, 1997 through October 28, 1998. The fourth quarterly report of 1998 for both units dated April 22, 1999 was also reviewed.

b. Observations and Findings

The inspectors reviewed NRC Inspection Report (IR) 50-250,251/98-01 concerning the maintenance rule team inspection. The (a)(3) periodic assessments required by the maintenance rule were reviewed for the previous cycle of Unit 3 operation October 8, 1995, through April 16, 1997. One of the comments was that the optimization of availability and reliability for Structures, Systems, and Components (SSCs) was not discussed. The inspectors found this issue discussed as one major section in the current periodic assessment for Unit 3. Five sections were discussed; summary, SSC performance during the period, (a)(1) SSCs, balance between availability and reliability, and program adjustments. The report discussed that each SSC that met both performance criteria for availability and reliability demonstrated an appropriate balance between the two. Under each SSC, if one of the performance criteria was not met, an adjustment was made to monitoring or preventive maintenance activities to restore balance. In addition, the overall core damage frequency due to the risk of performing on-line maintenance was addressed.

The fourth quarter report discussed six systems that were in a(1) status. Two systems were moved from a(2) to a(1) and two systems were moved from a(1) to a(2). There was a detailed discussion of each system including a bar chart of each system availability.

c. Conclusions

Maintenance rule reports were detailed and thorough. Previous NRC comments concerning optimization of availability and reliability were appropriately addressed.



M1.2 General Comments**a. Inspection Scope (61726, 62707)**

The inspectors observed all or part of the following work activities:

0-OSP-202.3	Safety Injection Pump and Piping Venting
0-OSP-074.3	Standby Steam Generator Feedwater Pumps Availability Test
3-OSP-049.1	Reactor Protection System Logic Test

These activities were performed professionally and no concerns were identified.

M2 Maintenance and Material Condition of Facilities and Equipment**M2.1 Diesel Driven Fire Pump****a. Inspection Scope (62707, 71750)**

On May 12, 1999, the inspectors observed a portion of the 18-month maintenance activities on the diesel driven fire pump (DDFP).

b. Observations and Testings

This maintenance activity was accomplished using procedures, O-PMM-016.1, DDFP 18 Month Maintenance Inspection and O-SME-016.1, DDFP 18 Month Maintenance Inspection. The electrical work replaced the DDFP batteries and checked interlocks. The inspectors observed checking of the engine cranking interlocks and alarms. The mechanical maintenance consisted of changing various filters, and completing operating tests. The inspector observed the overspeed test and 30 minute run. All measuring and test equipment was verified to have current calibration. Good communication was observed with the control room during testing. Good field support of the testing was noted by the presence of a design engineer, vendor representative, and auditor from nuclear assurance.

c. Conclusion

The maintenance activities on the diesel driven fire pump were well supported. The material condition of the pump was good .



III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Unit 4 High Head Safety Injection Venting

a. Inspection Scope (37551 and 71707)

The licensee's actions to address nitrogen leakage into the high head safety injection (SI) system were monitored and reviewed.

b. Observations and Findings

On May 1, 1999, the licensee identified that the cold leg injection line to the 4A reactor coolant system loop was hot to the touch. After potential leak paths were reviewed, the licensee concluded it was likely that the cold leg injection check valve (4-873A) was leaking. CR 99-0690 was initiated to address this issue. The licensee had recently cut and capped the SI test line due to accumulator back leakage through the test line (see IR 50-250,251/99-13 for details). Engineering's evaluation of the latest issue concluded that nitrogen from the 4A accumulator was leaking through check valve 4-873A; motor operated valves 4-843A and 843B; and valve 4-895U. Corrective actions included preparing work order packages to repair or replace the valves during the next short notice outage. In the interim, the licensee is venting the 4A and 4B SI pumps, the cold leg, and the test line once per day. Additionally, the 4A and 4B SI pumps are run on a weekly basis.

On May 18, 1999, the inspectors observed an operator perform venting of the system. The inspectors reviewed the procedures and prints and discussed the issue and the corrective actions with Operations and the responsible systems engineer. In addition, the inspectors reviewed the control room logs and verified the venting and the pump running were being performed as described in the licensee's corrective action documentation.

c. Conclusions

The licensee was aggressively pursuing corrective actions for slow nitrogen leakage into the high head safety injection system.

E8 Miscellaneous Engineering Issues

E8.1 (Closed) Unresolved Item 50-250,251/99-01-02: Control Over Software Changes

The licensee completed additional review and corrective actions for this item under Condition Report (CR) 99-0132. A 10 CFR 50.59 review of the computer program had been completed as part of Plant Change/Modification (PC/M) 96-022, Thermal Power Update Implementation. The inspectors reviewed PC/M 96-022 and discussed the computer program with engineering. The licensee's quality assurance organization had identified that all of the required documentation was not in the documentation control



records during an audit. The omission was attributed to a transition from the corporate office to the site of this software when the thermal power uprate package was approved by the NRC. In addition, the licensee reviewed 69 other software packages listed in the Computer Software Index. Two other minor documentation issues were identified. There were no cases in which a 10 CFR 50.59 review was not performed. The inspectors reviewed the assessment sheets performed for the 69 software packages. Based on this resolution and the extent of condition reviews, there were no 10 CFR 50.59 problems, and only minor issues of isolated incomplete documentation. This item is closed.

- E8.2 Year 2000 (Y2K) Readiness Program Review: The staff conducted an abbreviated review of Y2K activities and documentation using Temporary Instruction (TI) 2515/141, "Review of Year 2000 (Y2K) Readiness of Computer Systems at Nuclear Power Plants." The review addressed aspects of Y2K management planning, documentation, implementation planning, initial assessment, detailed assessment, remediation activities, Y2K testing and validation, notification activities, and contingency planning. The reviewers used NEI/NUSMG 97-07, "Nuclear Utility Year 2000 Readiness," and NEI/NUSMG 98-07, "Nuclear Utility Year 2000 Readiness Contingency Planning," as the primary references for this review.

During the review, the licensee stated that the Y2K Readiness Project activities were 99% completed for Category 1 and 2 items and 85% complete for category 3 items. Contingency planning was approximately 85% complete, and both programs were on target to be completed by their scheduled due dates.

Conclusions regarding the Y2K readiness of the facility are not included in this report. The results of this review will be combined with the results of reviews of other licensees in a summary report to be issued by July 31, 1999.

IV. Plant Support

P2.1 Hurricane Preparedness

a. Inspection Scope (71750)

The inspectors reviewed the licensee's procedures associated with hurricane preparedness and reviewed the licensee's hurricane season preparations.

b. Observations and Findings

The inspectors reviewed the licensee's procedures for protection against hurricanes. The procedures addressed equipment and flood protection, off-normal Operations, and emergency preparedness. Procedures and documentation reviewed included the following:

-EPAD-009	Hurricane Season Preparations
-0-ONOP-103.3	Severe Weather Preparations
-0-SMM-102.1	Flood Protection Stoplog and Penetration Seal Inspection

-0-EPIP-20106	Natural Emergencies
-0-EPIP-20101	Duties of Emergency Coordinator
-5610-C-1695	Network of Barriers for Main Plant External Flood Protection
-SFI 302	Security Force Instruction Hurricane Preparedness
-FSAR	Site and Environment

The licensee's procedures were comprehensive and thoroughly addressed equipment protection, Operations, emergency preparedness, and recovery. Lessons learned from previous hurricane experiences at the station were incorporated in the procedures.

The inspectors completed an independent review of the licensee's flood protection stop log procedures and equipment. Several minor issues were identified and communicated to the licensee. A review of the licensee's hurricane preparations and plant walkdown was also completed. Several issues had been identified and were appropriately documented in the licensee's corrective action program. At the start of the hurricane season, there were no significant open issues. Throughout the hurricane preparation activities, plant management was well involved in ensuring the preparations progressed in a timely manner.

c. Conclusions

The licensee was pro-active in preparations for the hurricane season. Procedures were comprehensive for equipment protection, Operations, emergency preparedness, and recovery.

P8 Miscellaneous EP Issues (92904)

P8.1 (Closed) Violation 50-250.251/97-12-04: Failure to follow 10 CFR 50.54(q) Requirement that Revision of the Radiological Emergency Plan (REP) Must not Reduce its Effectiveness. The inspectors reviewed the licensee's February 2, 1998, response to this finding. REP Revision 33 was issued in February 1998, to include the regulatory requirements that had not been adequately addressed. This item is closed.

F1 Control of Fire Protection Activities

F1.1 Fire Protection Monitoring

a. Inspection Scope (71750)

The inspectors reviewed the fire watch camera monitoring activities.

b. Observations and Findings

On May 13, 1999, during a routine plant walk down of the fire watch camera monitoring station, the inspectors identified several examples of incorrect labeling. Labels on the monitors identifying the camera viewing locations were not correct. Additionally, some of the viewing locations did not match the locations described in the controlled



documentation maintained at the work station. The inspectors noticed that scaffolding blocked the intended viewing area of one camera. Several security officers that monitored the cameras provided inconsistent replies when asked the location of various camera views. The licensee verified that the labeling was a problem and wrote CR 99-0750. The closed circuit camera monitoring system monitors 19 fire zones in the plant as compensatory posts for fire watch monitoring. The monitoring is a licensee commitment in response to NRC Bulletin 92-01, Failure of Thermo-Lag 330 Fire Barrier System to Maintain Cabling in Wide Cable Trays and Small Conduits Free From Fire Damage.

In reviewing this issue, the licensee found several examples of the camera sequencing that were incorrect. The sequencing was corrected and the fire protection procedures were revised to require that the camera sequences be checked each shift and after a monitor has been replaced. In addition, the licensee corrected the labeling on the controlled book to match the locations described by the monitors. The licensee determined that, although the camera viewing locations were incorrectly labeled, the specific cameras provided views to the same general area and therefore a fire would have been identified in the correct general area. The inspectors verified that the camera that was blocked by scaffolding was no longer required since Thermo-lag work in that area was complete. The inspectors reviewed the licensee's findings and corrective actions. No deviation from licensee commitments were identified.

c. Conclusions

Monitors being used to observe areas as a Fire Protection compensatory measure were not properly labeled. The indicated camera viewing locations were not correct. Corrective actions included revision of procedures to prevent recurrence. Fire Protection commitments were being met.

F4 Fire Protection Staff Knowledge and Performance

F4.1 Fire Drill In Cable Spreading Room

a. Inspection Scope (71750)

The inspectors observed a fire drill in the cable spreading room on June 2, 1999.

b. Observations and Findings

The inspectors observed that the fire brigade responded within minutes in full fire fighting equipment including portable breathing air bottles. Security also responded to the area. Fire team members checked fire panel alarms outside the cable spreading room and entered the room after feeling the entrance door for heat. A fire hose outside the entrance to the cable spreading room was broken out for use if needed. A portable halon cart was taken into the room for extinguishing the fire. Following the drill the inspectors attended the drill critique. The critique was timely and thorough.



c. Conclusion

The fire brigade responded satisfactorily during a fire drill in the cable spreading room.

F8 Miscellaneous Fire Protection Issues (92904)

F8.1 (Closed) Inspection Followup Item (IFI) 50-250.251/97-11-04: Validation of Fire Barrier Penetration Seals. The issue was related to the licensee's commitment (CTRAC 97-0370) to review and verify that fire barrier penetration seals were installed in accordance with design specifications bounded by configurations that had satisfactorily passed 3-hour fire resistance testing. Deviations from fire barrier configurations qualified by tests were to be evaluated.

The inspectors reviewed five fire protection evaluation reports that assessed penetration seals with ceramic fiber fill, large pipes, structural steel, electrical penetrants, and fire retardant coating materials that deviated from fire barrier penetration seal configurations qualified by tests. The licensee's fire barrier penetration seal engineering evaluations were complete and sufficiently documented penetration seal design and installation parameters that satisfied the guidance of NRC GL 86-10. Visual inspection of several seal installations identified in the fire protection evaluation reports did not identify any degradation of seal integrity or missing seals. These evaluation reports and inspections were discussed with a regional fire protection inspector. This item is closed.

V. Management Meetings and Other Areas

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on June 18, 1999. An Interim exit meeting was held on May 20, 1999 to discuss the findings of a year 2000 readiness review. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

D. Lowens, Quality Assurance Manager
 S. Franzone, Licensing Manager
 R. Hovey, Site Vice-President
 D. Jernigan, Plant General Manager
 T. Jones, Operations Manager
 J. Kirkpatrick, Protection Services Manager
 M. Lecal, Training Manager
 M. Pearce, Work Control Manager



R. Rose, Maintenance Manager
 E. Thompson, License Renewal Project Manager
 D. Tomaszewski, Site Engineering Manager
 J. Trejo, Health Physics/Chemistry Supervisor
 A. Zielowka, System Engineering Manager

Other licensee employees contacted included office, operations, engineering, maintenance, chemistry/radiation, and corporate personnel.

INSPECTION PROCEDURES USED

TI 2515/141: Review of Year 2000 (Y2K) Readiness of Computer Systems at Nuclear Power Plants
 IP 37551: Onsite Engineering
 IP 40500: Effectiveness of Licensee Controls in Identifying, Resolving and Preventing Problems
 IP 61726: Surveillance Observations
 IP 62707: Maintenance Observations
 IP 71707: Plant Operations
 IP 71750: Plant Support Activities
 IP 92903: Followup - Engineering
 IP 92904: Followup - Plant Support

ITEMS OPENED AND CLOSED

Opened

50-250, 251/99-03-01 NCV Independent Verification of Locked Valves (Section O1.2)

Closed

50-250, 251/99-03-01 NCV Independent Verification of Locked Valves (Section O1.2)

50-250, 251/99-01-02 URI Control Over Software Changes (Section E8.1)

50-250, 251/97-12-04 VIO Failure to follow 10 CFR 50.54(q) Requirement that Revision of the Radiological Emergency Plan (REP) Must not Reduce its Effectiveness (Section P8.1)

50-250, 251/97-11-04 IFI Validation of Fire Barrier Penetration Seals (Section F8.1)



50-250/99-02

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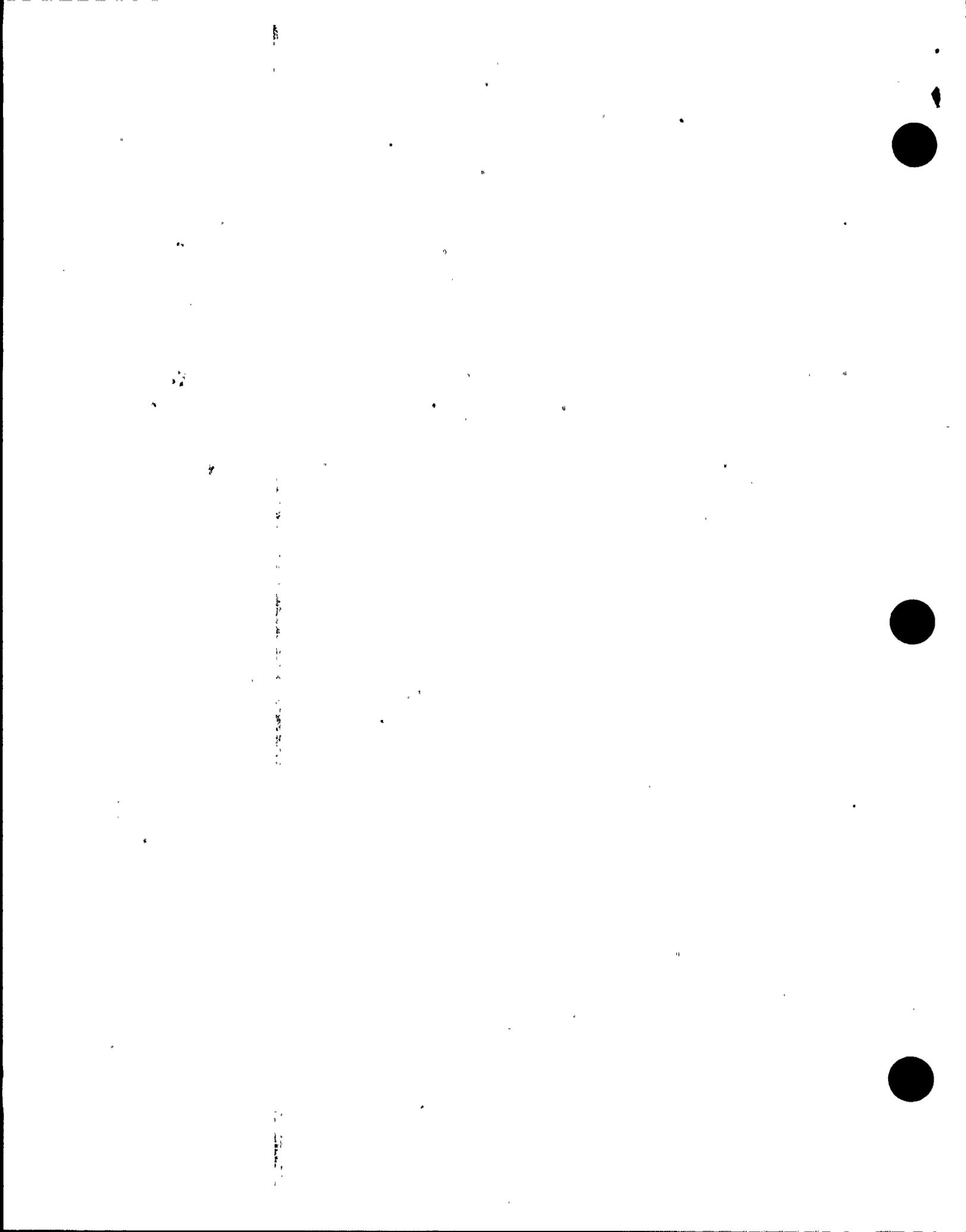
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REGION II
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June 18, 1999.

IA 99-29

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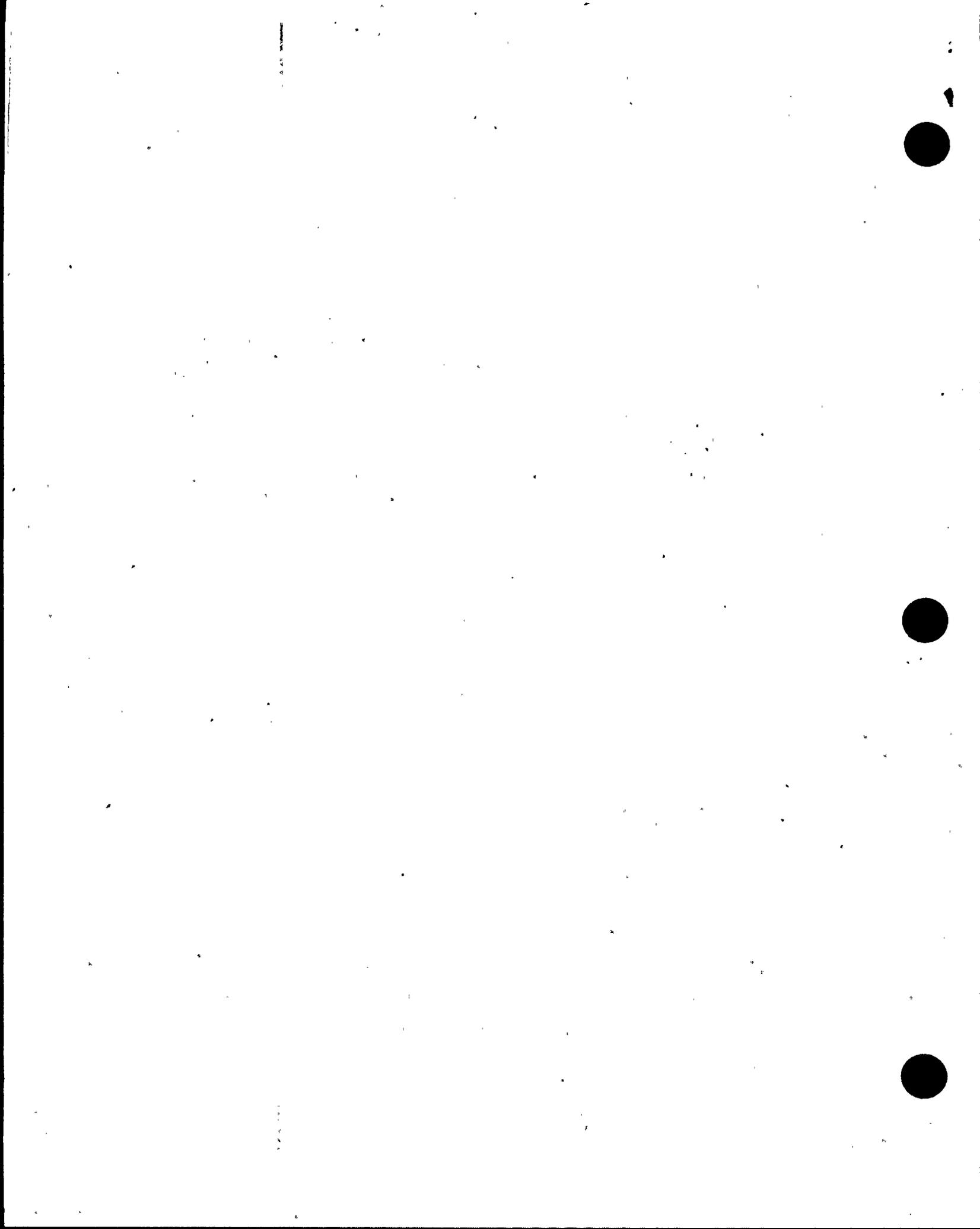
SUBJECT: NOTICE OF VIOLATION (NRC INTEGRATED INSPECTION REPORT
NOS. 50-250, 251/99-02)

The Nuclear Regulatory Commission (NRC) conducted an inspection on March 21 through May 1, 1999, at the Turkey Point Nuclear Plant. The inspection included a review of the licensee's Access Authorization Program for compliance with 10 CFR 73.56 and the Physical Security Plan. As part of this inspection, the NRC reviewed an incident identified by Florida Power and Light Company (FPL) involving your failure to disclose your criminal history during the pre-employment screening process at the Turkey Point Nuclear Plant. An excerpt from the report documenting the inspection in this area is provided as Enclosure 1.

The NRC's review of this matter indicated that you falsified an FPL "Personal History Questionnaire for Unescorted Access Authorization" (PHQ) when you failed to include a number of prior criminal charges. Based on the information you provided on the PHQ, you were granted temporary, unescorted access to both protected and vital areas at the Turkey Point Plant from September 21 through October 8, 1998. Subsequently, the licensee received your Federal Bureau of Investigation (FBI) fingerprint information which revealed four criminal charges not included on your PHQ. On December 21, 1998, the licensee terminated your access authorization as unfavorable based on the results of its review which revealed that you failed to disclose your complete criminal history on the PHQ. Also, when entering your information into the Plant Access Data System (PADS), FPL discovered that you possessed an active badge at the Virginia Electric and Power Company (VEPCO) Surry plant. Apparently, you also did not list criminal charges on your Security Questionnaire Update for Bartlett Nuclear which was used as the basis for granting your access to the Surry Nuclear Plant from October 14 through November 9, 1998.

Part 50.5 (a)(2) of Title 10 of the Code of Federal Regulations (10 CFR) provides, in part, that an employee of a licensee, or employee of a contractor or subcontractor of a licensee, may not deliberately submit to the licensee, or the licensee's contractor or subcontractor, information that the employee knows to be incomplete or inaccurate in some respect material to the NRC. You violated this requirement when you deliberately failed to report your full criminal history on the PHQ. Specifically, Page 4 of the FPL PHQ required that you list each incident of arrest, indictment, charge, conviction or detainment for violating any criminal law, and you failed to do so. A copy of 10 CFR 50.5 is provided as Enclosure 2. When interviewed by FPL regarding this matter, you stated that you were not sure why you did not completely list your criminal history.

The objective of the NRC's access authorization regulation, 10 CFR 73.56, is to provide a high degree of assurance that individuals granted unescorted access are trustworthy and reliable. One required element of this program is the completion of a background investigation including verification of criminal history. Failure to complete a full and accurate PHQ (one of the documents licensees review and evaluate as part of the background investigation) is material to the NRC, for the decision to grant unescorted access authorization is based on the licensee's



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assessment of information submitted by licensee employees and contractors. The NRC relies on accurate records of activities and the integrity of individual workers to ensure the health and safety of the public, and therefore, expects no less than full compliance with all applicable requirements.

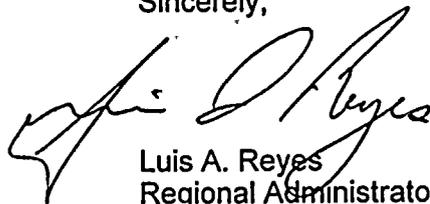
In this case, your failure to provide complete and accurate information regarding your criminal history circumvented the regulatory process. Therefore, after consultation with the Director, Office of Enforcement, the NRC has decided to issue the enclosed Notice of Violation (Notice), included as Enclosure 3. This decision was based not only on the fact that you violated the NRC's regulations regarding deliberate misconduct, but that you did it on more than one occasion. Under the circumstances of this case, considering the age and nature of the information not provided, this violation has been classified at Severity Level IV in accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions."

You are not required to respond to this letter. However, given your actions in this case, the Notice is being issued to you to emphasize the NRC's expectation that you provide complete and accurate information in all aspects of work at NRC licensed facilities. Should there be evidence of similar conduct on your part in the future, you may be subject to further enforcement action that could possibly include an Order prohibiting your involvement in NRC licensed activities for a term of years. A violation of 10 CFR 50.5 may also lead to criminal prosecution. Should you choose to provide additional information to the NRC regarding this matter, you should follow the instructions specified in the enclosed Notice and provide it to me within 30 days of the date of this letter.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, the enclosed Notice, and any response you provide, with personal privacy information removed, will be placed in the Public Document Room (PDR) after 45 days unless you provide a sufficient basis to withdraw this violation. To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

If you have any questions regarding this letter, please contact Kenneth P. Barr, Chief, Plant Support Branch at (404) 562-4653.

Sincerely,



Luis A. Reyes
Regional Administrator

- Enclosures: 1. Excerpt from Inspection Report
No. 50-250, 251/99-02
2. 10 CFR 50.5
3. Notice of Violation



NOTICE OF VIOLATION

Ronnie R. Johnson
[HOME ADDRESS DELETED
UNDER 10 CFR 2.790(a)]

IA 99-029

During an NRC inspection conducted on March 1 - May 1, 1999, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

10 CFR 50.5(a)(2) states, in part, that an employee of a licensee, or employee of a contractor or subcontractor of a licensee, may not deliberately submit to the licensee, or the licensee's contractor or subcontractor, information that the employee knows to be incomplete or inaccurate in some respect material to the NRC.

10 CFR 73.56 (b), requires in part, that nuclear power plant licensees establish and maintain an access authorization program which provides a high degree of assurance that individuals granted unescorted access to protected and vital areas of a nuclear power plant are trustworthy and reliable. The unescorted access authorization program must include a background investigation that verifies information concerning an individual's criminal history.

Contrary to above, you deliberately submitted information to Florida Power and Light Company (FPL) that you knew to be incomplete. Specifically, as of September 21, 1998, you failed to list four criminal charges on the FPL "Personal History Questionnaire for Unescorted Access Authorization" (PHQ) during the pre-employment screening process at the Turkey Point Nuclear plant. The charges you failed to list included: [10 CFR 2.790 Information] (March 8, 1992); [10 CFR 2.790 Information] (January 25, 1994); [10 CFR 2.790 Information] (August 3, 1996); and [10 CFR 2.790 Information] (July 4, 1997), as evidenced by the Federal Bureau of Investigation fingerprint information. As a result, you were granted unescorted access authorization to protected and vital areas of the Turkey Point Nuclear Plant between September 21 and October 8, 1998, and FPL was precluded from all pertinent information on which to conduct a full background investigation in accordance with 10 CFR 73.56 (b). Similar information was also omitted from your Bartlett Nuclear PHQ which was used as the basis for your access to protected and vital areas at the Surry Nuclear Plant from October 14 through November 9, 1998. (01014)

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

The NRC has concluded that information regarding the violation and the circumstances surrounding it are already known as addressed in the letter transmitting this Notice and Inspection Report 50-250; 251/99-02. However, you are required to submit a written statement or explanation pursuant to 10 CFR 2.201 if the descriptions therein do not accurately reflect the circumstances surrounding the violation. In that case, or if you choose to respond, clearly mark your response as a "Reply to a Notice of Violation" and send it to the U. S. Nuclear Regulatory Commission, ATTN: Regional Administrator, Region II, Atlanta Federal Center, 61 Forsyth Street, S. W., Suite 23T69, Atlanta, Georgia 30303-3415.

Enclosure 3



Notice of Violation

2

If you contest this enforcement action, you should also provide a copy of your response to the Director, Office of Enforcement, U. S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and the Enforcement Officer, Region II.

Because your response will be placed in the NRC Public Document Room (PDR), to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction. If personal privacy or proprietary information is necessary to provide an acceptable response, then, please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld and provide in detail the bases for your claim of withholding (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.790(b) to support a request for withholding confidential commercial or financial information). If safeguards information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

Dated at this 18th day of June, 1999



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RELEASE AFTER 45 DAY HOLD AND OE APPROVAL - EICS ACTION

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THIS ACTION MAY NOT BE RELEASED TO THE PDR OR OUTSIDE THE AGENCY WITHOUT THE APPROVAL OF OE

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OFFICE	RII:DRP	RII:DRS*	RII:ORA	OE	RII:ORA	RII:EKS	
Signature	<i>CC</i>	<i>ASm</i>	<i>NLO</i> <i>CE</i>	<i>PA...</i> <i>D. Nelson</i>		<i>AB</i>	
NAME	CCASTO	SMALLETT	CEVANS	LIEBERMAN	JJohnson	ABoland	
DATE	4/17/99	6/15/99	6/15/99	4/19/99	1/99	6/18/98	1/98
COPY?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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