



February 6, 1997

L-97-020
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 and Proposed Civil Penalties
NRC Inspection Reports 96-19, 96-18, and 96-22

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

We share your concerns related to the identified significance of these issues. As discussed in the attachment, we are taking corrective actions to avoid future violations in these areas. The lack of responsiveness to the employee concerns pertaining to emergency preparedness has been addressed through organizational and process improvements identified in the St. Lucie Plant Self-Assessment. Our policies and processes are intended to ensure that employees are free to raise safety concerns and that concerns are responded to in a prompt and appropriate manner. We will address this topic further in a meeting on February 13, 1997.

The previous lack of management commitment to the emergency preparedness program, as evidenced by these violations, has been remedied. St. Lucie Plant managers are focused on ensuring that the highest quality and levels of emergency preparedness and emergency response readiness are maintained. The importance and visibility of, and focus on, an effective emergency preparedness program have been raised to the highest levels at St. Lucie Plant.

With regards to the access control and missed reporting violations, we have taken steps to make sure that the accountability rests on the plant's managers for ensuring that people who have protected or vital area access, in fact, only have access to the plant at the level required. Again, we are reinforcing this accountability on a day-to-day basis. The regulatory requirement for prompt reporting in accordance with the Federal Regulations is an additional item of management and plant worker attention, not only in security but in all the reporting requirements of Part 50 of Title 10 of the Code of Federal Regulations.

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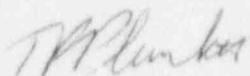
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The payment of civil penalties in the amount of \$100,000 is being made separately by electronic funds transfer. If you have questions on this response, please contact us.

Very truly yours,



T. F. Plunkett
President
Nuclear Division

TFP/JAS/REN

Attachment

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

STATE OF FLORIDA)
)
COUNTY OF ST. LUCIE) SS.

T. F. Plunkett being first duly sworn, deposes and says:

That he is President, for the Nuclear Division of Florida Power & Light Company, the Licensee herein;

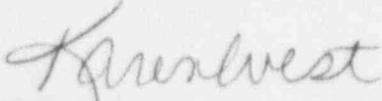
That he has executed the foregoing document; that the statements made in this document are true and correct to the best of his knowledge, information and belief, and that he is authorized to execute the document on behalf of said Licensee.



T. F. Plunkett

STATE OF FLORIDA
COUNTY OF ST. Lucie

Sworn to and subscribed before me
this 6th day of February, 1997
by, T. F. Plunkett who is personally known to me.



Signature of Notary Public-State of Florida

KAREN WEST

Name of Notary Public (Print, Type, or Stamp)



KAREN WEST
MY COMMISSION # CC358826 EXPIRES
April 18, 1998
BONDED THRU TROY FAIR INSURANCE, INC.

Violation A of Part I

10 CFR 73.55(7) states that licensees shall establish an access authorization system to limit unescorted access to vital areas during non-emergency conditions to individuals who require access in order to perform their duties.

The licensee's Physical Security Plan (PSP), Revision 48, dated February 23, 1996, states, "Only those individuals with identified need for access and having appropriate authorization shall be granted unescorted Vital Area access."

Contrary to the above, between July 28 and September 19, 1996, an individual, whose employment terminated on July 28, 1996, had unescorted access to protected and vital areas without appropriate authorization, and on August 7, August 9, and August 15, 1996, actually entered the protected area and had access to vital areas. In addition, as of the end of the onsite inspection on October 25, 1996, five additional individuals whose employment terminated during the period July 27 through September 19, 1996, were identified by the licensee as having had unescorted access to the protected and vital areas, without appropriate authorization.

1. FPL Concurrs with the violation.

2. **REASON FOR VIOLATION**

The Licensee failed to adequately implement the provisions of site procedures requiring immediate notification of security by the terminated employees' supervisor when site access was no longer required. In addition, the terminated individuals failed to follow termination procedures outlined in General Employee Training and the Nuclear Division Human Resources Department failed to notify Security when site access for the employees was no longer required.

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

- A. Upon discovery of terminated employment, Security unassigned the card keys for the individuals.
- B. Department heads were directed to validate the need for continued plant access for all licensee and contractor employees under their cognizance. The validation was completed on November 1, 1996.

- C. The Access Control Specialist used a 30 day access non-use list to verify that individuals who had not used their card key within the last 30 days were still employed. This was completed on October 24, 1996 and no discrepancies were noted. Only currently active badges appear on this report.
- D. Security verified, from a list supplied by FPL Human Resources, that all FPL Nuclear Division employees released since January 1, 1996 did not retain site access. Twenty-four more individuals were found to have had access beyond their termination dates, but none of these individuals had gained access to the protected or vital areas of the plant. These individuals would not appear on the above mentioned non-use report because their badges were already unassigned.

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

- A. Plant Administrative Procedure 0010509, was revised to include a requirement to identify employees as either full time or temporary. For temporary employees, a date when site access will be terminated is now required. This procedure was also revised to include a processing checklist that specifies notifying security to remove unescorted access authorization as a required action which must be completed upon termination of employment. The 31 day review for vital area access was revised to require a review by plant departments to ensure that listed personnel require ongoing access to the plant. The review is required to be returned to Security with such an endorsement.
- B. Site management and specific plant supervisory personnel were trained on the revised procedures and requirements concerning the necessary interface between site departments and Security for gaining site access and termination. This topic was completed in a computerized training brief for plant supervisors and managers on December 10, 1996. Additionally, this information was included in the initial sessions of the "Basics Of Supervision" course which was completed by December 31, 1996. Make up sessions are scheduled for completion by February 28, 1997.
- C. Company-wide guidance was developed to outline the interface requirements between Human Resources, Security, and site department when terminating an individual's employment with FPL for any reason.

5. Date when full compliance was achieved:

Full compliance was achieved on December 31, 1996, with the exception of make up classes of the "Basics Of Supervision" course, which will be completed by February 28, 1997.

Violation B of Part I

10 CFR 73, Appendix G, Section I(b) requires that an actual entry of an unauthorized person into a protected area or vital area be reported to the NRC within one hour of discovery.

10 CFR 73, Appendix G, Section II(a) states that any failure, degradation, or discovered vulnerability in a safeguards system that could have allowed unauthorized or undetected access to a protected area or a vital area had compensatory measures not been established, be recorded within 24 hours of discovery in the safeguards event log.

Contrary to the above, on October 9, 1996, the licensee failed to report to the NRC an actual entry of an unauthorized person into the protected area within one hour of discovery. Specifically, on October 9, 1996, the licensee discovered that an unauthorized individual who had been terminated on July 28, 1996, had entered the protected area on five different occasions, yet the licensee did not report the incident to the NRC until October 16, 1996. In addition, on September 19, 1996, the licensee failed to record a vulnerability of the safeguards system in the safeguards event log. Specifically, the licensee discovered three individuals who had been terminated on July 27, 28, and August 24, 1996, who could have accessed the protected areas of the plant due to their access badges not being terminated. The licensee failed to report this discovery in the safeguards event log.

1. FPL Concur with the violation.

2. **REASON FOR VIOLATION**

Failure to provide timely notification to the NRC was caused by human error when malevolent intent was used as a criteria for making a one hour report. This was an error in properly interpreting regulations and site procedures on reporting of this Safeguards event.

Additionally, the missed regulatory requirement of prompt reporting was the result of Security personnel not following the plant's established process for identifying, evaluating, and tracking to closure problems and conditions found in the plant and its processes. The plant's problem reporting process, called "Condition Reports," was not used in a timely manner to document the unauthorized access. Accordingly, the reportability requirement of the unauthorized access was not properly identified to, and evaluated by, all knowledgeable and accountable plant organizations.

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

On October 16, 1996, a one-hour report was made to the NRC.

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

Security personnel were re-instructed on security reportability requirements by conducting a detailed review of all relevant regulatory documentation on reportability requirements. Additionally, the requirement to document problems and potentially reportable occurrences using Condition Reports is reinforced on an ongoing basis by plant management personnel. Documentation in Condition Reports ensures timely notification to management of potentially reportable occurrences.

5. Date when full compliance was achieved:

Full compliance was achieved with completion of items 3 and 4, above, on November 4, 1996.

Violation A of Part II

10 CFR 50.54(q) requires that nuclear power plant licensees follow and maintain in effect emergency plans which meet the planning standards of 10 CFR 50.47(b) and the requirements in Appendix E to 10 CFR Part 50.

Section 2.4 of the licensee's Radiological Emergency Plan (REP), Revision 31, stated that activation of the Technical Support Center (TSC) and the Operational Support Center (OSC) will be initiated by the Emergency Coordinator in the event of an Alert, Site Area Emergency, or General Emergency, and that arrangements have been made to staff the TSC and OSC in a timely manner. Also specified is that activation of the Emergency Operations Facility (EOF) is required for a Site Area Emergency or General Emergency, and that arrangements have been made to activate the EOF in a

timely manner.

The REP requirements delineated above were implemented, in part, by Emergency Plan Implementing Procedure (EPIP) 3100023E, "On-Site Emergency Organization and Call Directory," Revision 72. The instruction in Section 8.2 of this procedure stated that, upon the declaration of an emergency classification, "the Duty Call Supervisor will initiate staff augmentation" using the "Emergency Recall System or Appendix A, Duty Call Supervisor Call Directory, to notify persons...."

Contrary to the above, from approximately July 22 to October 3, 1996, arrangements were not available to staff or activate the TSC, OSC, or EOF in a timely manner because the licensee did not have the capability to adequately implement either the primary method (using the Emergency Recall System) or the backup method (using the Duty Call Supervisor Call Directory) for notifying its personnel during off-hours.

1. FPL concurs with the violation.

2. **REASON FOR VIOLATION**

The Emergency Recall System (ERS) autodialer was inoperable due to an improper "as left" configuration following revision of the personnel database. Emergency Preparedness Department personnel did not have a process in place to retest the autodialer following maintenance of the computer database. Additionally, the manual backup method specified in the Emergency Plan Implementing Procedures (EPIPs) was also deficient during this same period, in that a controlled copy of the notification implementation procedure was not distributed to all applicable personnel. A process to verify distribution of the backup manual call out procedure to all members with call out responsibility was also not in place. Both augmentation methods also had a common problem in that call out drills were performed infrequently.

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

A. Upon detection of the autodialer inoperability on October 3, the computer database configuration error was promptly corrected. The autodialer was then thoroughly tested. Testing included a limited call out test following immediate corrective actions to confirm repairs and a communication drill was conducted on October 4, 1996. Test results were satisfactory.

B. Verbal instructions were given to personnel typically involved with maintaining

the autodialer as to the nature of the database error and how to avoid it in the future.

- C. Copies of the manual call out procedure were distributed to all Emergency Response Organization (ERO) members with call out responsibility.
- D. Individual training on the manual call out process was given to those personnel with call out responsibility.
- E. A manual call out drill was performed on October 10, 1996 to test the proficiency of the responders. Test results were satisfactory.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

- A. A department instruction was written (PSG-15, "Maintenance and Testing of the Emergency Recall System") to control changes to the autodialer. The instruction includes limiting authorization, defining the scope of the change and performing testing following changes.
- B. Personnel performing manual call outs are required to attend training prior to being placed in the ERO. This process is controlled by EPIP 3100034E.
- C. Personnel performing manual call outs are verified as receiving controlled distribution of the Emergency Response Directory (ERD). The department instruction to control the process was approved on February 4, 1997.
- D. Periodic notification drills will be conducted to test the operation of the autodialer and proficiency of the responders.

5. Date when full compliance was achieved:

Full compliance was achieved on October 7, 1996 with the implementation of 3A and 3C above.

Violation B of Part II

Section 1.3 of the REP stated, "This plan outlines company responsibilities within the framework of the overall emergency response organization, and provides a conceptual basis for the development of the detailed procedures necessary to implement the plan."

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Section 1.4 of the REP stated, "Associated with this Emergency Plan are implementing procedures which provide a source of pertinent information and data required by the response organization during an emergency."

Contrary to the above, as of November 1, 1996, detailed procedures to provide a source of pertinent information required by the response organization during an emergency were not adequately developed with respect to the following aspects of the Emergency Plan:

1. recovery activities, as discussed conceptually in REP Section 5.4, and
2. the description and delineation of the licensee's emergency response organization (ERO) and the detailed means for notifying ERO members in an emergency, as discussed generally in REP Section 2.2.

1. FPL concurs with the violation.

2. **REASON FOR VIOLATION**

1. The post accident recovery operations referenced in the violation were contained in an FPL corporate document and applicable to all Nuclear Division sites. The information was documented in a manner consistent with other nuclear utilities and was incorrectly judged to be adequate by FPL.
2. The ERO structure and notification methodologies were listed in several EIPs. The Emergency Response Directory contained personnel phone numbers used for staff augmentation. A change in EPIP 3100023E "On-Site Emergency Organization and Call Directory", was implemented on November 13, 1996. This revision re-located an example call tree and call out instructions to EPIP 3100023E from the Emergency Response Directory.

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

- A. Additional post emergency recovery elements were included in EPP-15, "Activation and Use of the Emergency Operations Facility".
- B. The descriptions of the ERO and the call tree notification were added to the site's call out procedure (EPIP 3100023E "On-Site Emergency Organization and Call Directory"). The EPIP contains call out instructions and call tree

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descriptions. A separate document was developed (St. Lucie Emergency Response Directory) to contain the list of names and phone numbers for the response organization.

- C. A program weakness was referenced by the NRC in EA 96-464 Enclosure 2. The weakness dealt with inadequate EPIPs for the relocation of the OSC. The governing EPIP (3100032E) was changed and implemented on October 11, 1996 to provide specific criteria for the Emergency Coordinator to use when considering relocation. This change was reviewed with the NRC inspectors during the course of their inspection.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

Instructions will be written to control the review and revision of the Recovery Plan by February 28, 1997.

5. Date when full compliance will be achieved:

Full compliance was achieved on January 28, 1997 with the completion of 3A and 3B above.

Violation C of Part II

REP Section 7.2.1, "Objectives," stated the following: "The primary objectives of emergency response training are as follows: 1. Familiarize appropriate individuals with Emergency Plan and related implementing procedures. 2. Instruct individuals in their specific duties to ensure effective and expeditious action during an emergency. 3. Periodically present significant changes in the scope or content of the Emergency Plan. 4. Provide refresher training to ensure that personnel are familiar with their duties and responsibilities."

REP Section 7.2.2, "Training of On-Site Emergency Response Organization Personnel," stated, in part, "For employees with specific assignments or authorities as members of emergency teams, initial training and annual retraining programs will be provided. Training must be current to be maintained on the site Emergency Team Roster." REP Section 7.3.2 stated, "The Plant Training Manager will ensure that on-site Emergency Response Organization personnel are informed of relevant changes in the Emergency Plan and Emergency Plan Implementing Procedures."

Contrary to the above, the licensee failed to adequately implement the training requirements specified in the REP as evidenced by the following examples:

1. In calendar year 1994, the licensee failed to provide initial training or annual retraining for 17 positions (approximately 92 individuals) identified as part of the onsite response organization. In calendar year 1995, the licensee failed to provide initial training or annual retraining for eight positions (approximately 54 individuals) identified as part of the onsite response organization.
2. During calendar years 1994 and 1995, the licensee's training program failed to include initial training or annual retraining on certain procedures required to be implemented by ERO personnel in several identified positions. Examples include: EPIP 3100027E, "Re-entry," required to be implemented by the Emergency Coordinator, Radiation Team Leader, Operations Support Center (OSC) Supervisor, Re-entry Team Supervisor, Re-entry Team Member, OSC Status Board Keeper, and OSC Dose Recorder; EPIP 3100026E, "Criteria for and Conduct of Evacuation," required to be implemented by the Emergency Coordinator, Assembly Area Supervisor, and TSC Security Supervisor; and EPIP 3100035E, "Off-site Radiation Monitoring," required to be implemented by the Radiation Team Leader and TSC Supervisor.

In addition, during calendar years 1994 and 1995, the Plant Training Manager failed to ensure that ERO personnel in several identified positions were informed of relevant changes in procedures. Specifically, EPIP 3100026E was significantly revised in September 1994 and in February 1995 yet the positions required to implement it, the Emergency Coordinator, Assembly Area Supervisor, and TSC Security Supervisor, had not been informed of the changes.

3. For calendar year 1995, the licensee failed to remove from the emergency response organization two individuals who had not completed retraining as required and whose qualifications had expired in 1994. The licensee also failed to remove six individuals from the emergency team roster effective October 6, 1996, who had not remained qualified to fill response team requirements as a result of allowing their respirator qualifications to lapse.

1. FPL concurs with the violation.

2. **REASON FOR VIOLATION**

Inappropriate attention to the importance of EP training and drill participation, combined with a failure by EP personnel to ensure that required Emergency Plan elements were properly implemented, caused this condition. A lack of attention and sensitivity to the importance of emergency preparedness training by the plant's management resulted in the low prioritization of emergency preparedness training.

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

A. The ERO roster was promptly revised to remove any unqualified personnel.

B. The ERO training program was significantly upgraded:

1. All response positions are included in the responder training program.
2. EIPs referenced in the violation are included in the program.
3. A matrix was developed to link the ERO position to the required training.
4. Training modules were developed in a format consistent with accredited training.

C. Facility orientation training was conducted as well as a series of facility drills to provide additional training to ERO members.

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

A. EPIP 3100034E will be revised to implement a quarterly drill program with the expectation that ERO members will participate in at least one drill per calendar year. This procedure will be issued by April 1, 1997.

B. EPIP 3100034E "Maintaining Emergency Preparedness-Emergency Response Plan Training" has been improved to specify the required training for each ERO position. Training is in progress to conform to the increased training requirements. Implementation of the upgraded requirements of EPIP 3100034E is April 1, 1997.

C. ERO members in positions that were previously excluded from initial or

requalification, are currently being trained. Training will be complete by March 31, 1997.

- D. A site process to identify training on significant procedure revisions (QI 5/1 "Preparation, Review and Approval of Procedures") prior to procedure issue has been approved.
 - E. A department instruction that describes the periodic review of the ERO was completed on February 3, 1997.
5. Date when full compliance is achieved:

Full compliance will be achieved on April 1, 1997 with the completion of item 4B above.

Violation A of Part III

10 CFR 50, Appendix B, Criterion III, Design Control, requires, in part, that measures be established to assure that applicable regulatory requirements and the design basis, as defined in 10 CFR 50.2 and as specified in the license application, for those structures, systems, and components to which this appendix applies, are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of the design. The verifying or checking process shall be performed by individuals or groups other than those who performed the original design, but who may be from the same organization.

FPL Topical Quality Assurance Report, TQR 3.0, Revision 11, "Design Control," Section 3.2.4, "Design Verification," stated, in part, "Design control measures shall be established to independently verify design input....Design verification shall be performed by technically qualified individuals or groups other than those who performed the design."

Engineering Quality Instructions (QI) 1.7, Design Input/ Verification, dated July 5, 1995, stated, in part, "Design verification is the process whereby a competent individual, who has remained independent of the design process, reviews the design inputs.... and design output to verify design adequacy. This independent review is provided to minimize the likelihood of design errors in items that are important to nuclear safety."

Engineering QI 3.7, Computer Software Control, dated July 5, 1995, stated, in part,

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(1) a Software Requirements Specification shall be prepared which identifies and describes the function, performance, constraints, attributes, external interfaces, and user documentation requirements of the computer software; (2) validation and verification (V&V) of newly developed computer software shall be completed prior to use; and (3) V&V results shall be reviewed by an independent individual other than the developer of the software.

Contrary to the above:

Example 1

As of July 30, 1996, the licensee failed to verify the adequacy of design change PC/M 009-195 by individuals other than those who performed the original design, in that design change PC/M 009-195, which was utilized to install new safety-related nuclear instrumentation system drawers on Unit 1, did not receive an independent design verification by a competent individual independent of the design process.

Example 2

As of July 30, 1996, the licensee failed to provide for verifying the adequacy of a new core flux monitoring computer code on Unit 1, which was procured as category SQA1 software, in that the software constraints and attributes with regard to adjustments for the core midplane offset were not clearly documented and verification and validation by a competent individual independent of the design process was not conducted.

Response to Violation A of Part III

1. FPL concurs with the violation.

2. **REASON FOR VIOLATION**

Example 1

The primary causes of Example 1 of the violation were: 1) cognitive personnel error in that the design drawings for the NI cabinet contained wiring connection errors that were not identified by personnel performing the independent verification; and 2) weaknesses in the design verification process that contributed to the personnel error. The weaknesses in the verification process were due to the following factors: A) The engineering design verification process allowed the drawings to receive a drafting check instead of an independent design review by an experienced engineer; and B) similarity between Unit 1 and Unit 2 was credited during the verification process (the modification had successfully been implemented on Unit 1); and C) draft vendor information was used in the design preparation without reverification after final vendor documentation was received. Although items A) and B) had been interpreted as being acceptable under Engineering Quality Instructions in place at the time, Item C) was not consistent with the engineering design process requirements.

Example 2

The primary cause of Example 2 is the result of an inadequate treatment of a core midplane modeling offset used in the reload nuclear design and safety analysis. This modeling offset was inconsistently applied in the BEACON core monitoring software input assumptions. The error in the BEACON model was a result of (1) a failure to document formally the use of a modeling offset in the reload nuclear design and safety analysis for the core midplane offset such that individuals working on subsequent BEACON software input would understand that the core midplane offset had to be consistently applied, and (2) a failure to provide adequate independent verification that the final BEACON software input assumptions were consistent with the reload nuclear design and safety analysis assumptions. The failure to document the modeling offset was also a contributing factor to the failure to provide adequate independent verification.

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

Example 1

- A. Within one hour of confirmation of the reversed NI drawer leads, the leads were corrected to achieve the proper alignment.

- B. Revisions were made to the engineering verification process to require signature of an independent competent engineer on all safety related design drawings issued with a Plant Change/Modification.
- C. Revisions were made to the engineering design process to require the same level of verification on duplicate packages, and to state that similarity between units should not be credited during the verification process.
- D. The engineering training program has been revised to include training in the design and verification process for both the initial and continuous training program.

Example 2

- E. The effect of the mid-plane offset was quantified and dispositioned using available margin.
- F. The Beacon geometry data was revised to be consistent with the safety analysis.
- G. A comparison of Beacon outputs to predicted values confirmed that there were no additional problems with the system.
- H. The excore NIs were recalibrated using the corrected Beacon model.

4. CORRECTIVE STEPS TO AVOID FURTHER VIOLATIONS

Example 1

- A. An Engineering Department meeting (which included the President of the Nuclear Division, the St. Lucie Site Vice President, and the Vice President of Nuclear Engineering) was held to discuss the event, lessons learned, and to reinforce management expectations.
- B. Approved safety related electrical engineering design packages which were in the process of being implemented or were scheduled to be implemented were reviewed and re-verified as necessary to insure the verification process weaknesses did not adversely affect other engineering design changes. No other design errors were discovered as a result of this review.

Example 2

- C. The modeling offset will be eliminated for next refueling cycle.
 - D. The Fuel design standard was revised to require revalidation of these key reload nuclear design and safety analysis assumptions when changing an assumption for reload nuclear design, safety analysis or core monitoring models or software.
 - E. To strengthen independent verification the Fuel design standard was revised to require a design review meeting for any fuel design change, (including axial shifts or dimension changes in the active fuel column) for the design model being developed. This design review must address the impact of modeling changes on nuclear design, safety analysis or core monitoring models or software.
5. Full compliance was achieved on September 11, 1996, with the completion of Items 3A, 3F, 3G and 3H, above.

Violation B of Part III

Technical Specification 6.8, Procedures and Programs, Paragraph 6.8.1, requires, in part, that written procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, dated February 1978, shall be established and implemented.

Administrative Procedure No. 0006130, Condition Reports, Revision 4, dated March 22, 1996, Paragraph 8.1.1.A, stated, in part, that "Any individual who becomes aware of a problem or discrepant condition...should initiate a CR [Condition Report]. If doubt exists, a CR form should be initiated."

Contrary to the above, on July 30, 1996, Instrument and Control technicians installing Modification PC/M 009-195 did not initiate a Condition Report when they became aware of a discrepant condition, i.e., that markings for electrical terminal connectors on replacement detectors differed from cable markings identified on the control wiring diagrams. The failure to resolve the discrepant condition resulted in incorrectly installing an excore nuclear instrumentation system detector in Unit 1.

Response Violation B of Part III

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

The principle cause of the violation was personnel error in that the formal process for resolving discrepancies in the field was not followed. The cable markings on a replacement excore NI detector were identified as being different from the existing cable markings. This discrepancy should have been formally identified on a St. Lucie plant Condition Report (CR) as required by plant administrative procedures. Instead an informal approach was followed in resolving the discrepancy which led to the detector being miswired. This appears to be an isolated incident and not a programmatic issue with the CR system. This is evidenced by the fact that thirteen CRs were written and dispositioned during the Excore NI detector and drawer replacements and approximately 3000 CRs in all have been written to date.

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

- A. A change request notice was approved to revise the detector cable connection drawings and proper operation of the affected channel was confirmed.

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

- A. Condition Report procedural requirements were emphasized at "stand-down" meetings.
- B. The detector vendor has provided additional documentation to clarify the cable designations.

5. Full compliance was achieved on July 30, 1996, with the completion of Item 3A, above.