

1501 Port St. Lucie Boulevard, Suite
Port St. Lucie, FL 34952
(561) 337-5800
FAX: (561) 335-3993

The Port St. Lucie News

FOIA/PA REQUEST

Dec. 18, 1997

Case No: 97-484
Date Rec'd: 12-22-97
Action Off: Pool
Related Case: _____

To the office of:
Mary Jean Pool
Freedom of Information Act Branch
U.S. Nuclear Regulatory Commission
11545 Rockville, MD 20852-2738

Ms. Pool:

Pursuant to Section 119.07 (1) (a), Florida Statutes and the U.S. Freedom of Information Act, I am requesting access to certain public records. In reference to our conversation today, I am requesting further access to these twenty two (22) NRC files:

* RII-1994-A-0119	* RII-1995-A-0001	* RII-1995-A-0033
* RII-1995-A-0065	* RII-1995-A-0183	* RII-1995-A-0186
* RII-1995-A-0199	* RII-1995-A-0200	* RII-1996-A-0029
* RII-1996-A-0035	* RII-1996-A-0120	* RII-1996-A-0122
* RII-1996-A-0130	* RII-1996-A-0150	* RII-1996-A-0175
* RII-1996-A-0180	* RII-1996-A-0192	* RII-1996-A-0251
* RII-1997-A-0015	* RII-1997-A-0027	* RII-1997-A-0053
* RII-1997-A-0116		

Specifically, we are looking for several portions of these files and will likely not need the entire files. Below are lists of portions we are requesting:

- * The initial allegation
- * The allegor identification sheet
- * The case chronology
- * The investigation report
- * Any documents regarding a conclusion, summary or recommendation for changes

If copies are needed, *The Port St. Lucie News* will pay the reasonable costs, as defined by Florida law. Please fax any and all results of the request to (561) 335-3993. If a fax is not possible, the results may be mailed to the above address.

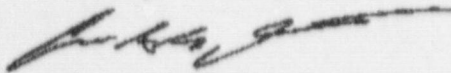
If you believe you are not required to disclose any or all of the documents in your possession which fall within the scope of the foregoing request, please be advised of the requirements of Section 119.07 (2) (a), Florida Statutes. This statute provides that, if a person who has custody of

§ public record contends that the word or part of it is exempt from inspection and examination, that person must state the basis of the exemption which is believed to be applicable to the public record, including the statutory citation to an exemption created or afforded by statute, and, if requested by the person seeking to inspect, examine and copy the record, the custodian of the record must state in writing and with particularity the reasons for his conclusions that the record is exempt.

Pursuant to the foregoing statutory provision, if you believe the records requested above, or any portions of those records, are exempt from inspection, examination and copying, please provide a written statement describing with particularity the reasons and the statutory basis for your conclusion.

Thank you in advance for your prompt attention to this matter. If you have any questions or concerns, do not hesitate to contact me at (561) 337-5826 or fax to (561) 335-3993.

Sincerely,



Eric Alan Barton
The Port St. Lucie News

January 16, 1996

CASE CHRONOLOGY

RII-95-A-0001

FACILITY: ST LUCIE

OPENED BY: O. DEMIRANDA

DATE/INT'LS	ACTIVITY	SECTION
1/03/95;ODM	NMSS ALLEG REPORT. ALLEG: ARMS ROOM DOOR LEFT OPEN AND UNATTENDED	1
1/03/95;ODM	ALLEGER IDENTIFICATION SHEET	4
1/03/95;ODM	INDEX OF CONCERNS	1
1/05/95;ATB	ALLEGATION REVIEW PANEL: DRP RESIDENT PERFORM AN INITIAL CHECK FOR REQUIREMENTS. NMSS WITH LEAD INSPECTION AND CLOSEOUT RESPONSIBILITY.	2
6/04/95;ATB	RECEIVED CLOSEOUT MEMO FROM NMSS INCLUDING INSPECTION REPORT AND ALLEGATION EVALUATION REPORT. THE EVENT WAS SUBSTANTIATED; HOWEVER, NO VIOLATIONS OF NRC REQUIREMENTS RESULTED.	3
9/15/95;ATB	ATB CONTACTED ALLEGER TO OBTAIN LAST NAME AND ADDRESS. UPDATED ALLEGER IDENTIFICATION SHEET.	4
9/15/95;ATB	ATB REVIEWED CASE FILE.	NONE
1/10/96;ATB	ATB REVIEWED CASE FOR CLOSURE PROVIDED CLOSURE LETTER TO ALLEGER FOR D/EICS REVIEW.	
1/11/96;ATB	CLOSEOUT LETTER TO ALLEGER ISSUED.	5
01/16/96;ODM	SAC QA AMS AND PROVIDE COPY FOR FILE	5

E/1

January 10, 1996

INDEX OF CONCERNS

ST LUCIE

RII-95-A-0001

NO.	DESCRIPTION	LOCATION
1/1	ARMS ROOM DOOR LEFT OPEN AND UNATTENDED	Date: 01/03/95 ALLEG RPT
ACTION: ARP CONDUCTED ON 1/05/95. DRP TO PERFORM AND INITIAL EVALUATION OF THE LICENSEE'S REQUIREMENTS. NMSS TO INSPECT FOR CLOSURE.		
CLOSURE: ONSITE INSPECTION CONDUCTED ON MARCH 27-31, 1995, AND DOCUMENTED IN IR 50-335, 389/95-05. THE EVENTS DESCRIBED BY THE ALLEGER WERE CONFIRMED; HOWEVER, NO VIOLATION OF NRC REQUIREMENTS WAS IDENTIFIED.		
2/	_____ _____ _____	Date: __/__/__ Page: _____ para: _____
ACTION:		
CLOSURE:		
3/	_____ _____ _____	Date: __/__/__ Page: _____ para: _____
ACTION:		
CLOSURE:		
4/	_____ _____ _____	Date: __/__/__ Page: _____ para: _____
ACTION:		
CLOSURE:		
5/	_____ _____ _____	Date: __/__/__ Page: _____ para: _____

E/2

July 26, 1996

CASE CHRONOLOGY

RII-95-A-0183

FACILITY: ST. LUCIE		OPENED BY: O. DEMIRANDA
DATE/INITIALS	ACTIVITY	SECTION
11/16/95;ODM	EICS ALLEGATION REPORT ALLEG: (1) HEALTH PHYSICS CONCERNS INVOLVING POOR CONTROL OF CONTAMINATED TOOLS, LACK OF TRAINING FOR HEW HIRES, PERSONNEL CONTAMINATION EVENT, (2) LACK OF MANAGEMENT RESPONSE TO CONCERNS AND EFFECTIVENESS OF SPEAKOUT	1
11/16/95;ODM	ALLEGER IDENTIFICATION SHEET (ANONYMOUS)	4
11/16/95;ODM	INDEX OF CONCERNS	1
11/17/95;ODM	SAC ENTER ALLEGATION IN AMS	NONE
12/07/95;ODM	ALLEGATION REVIEW BOARD MEETING MINUTES AP: DRS INSPT HP ISSUES IN CONCERN #1 WEEK OF FEB 26, 1995. DRS DEVELOP PLAN FOR REVIEWING SPEAK OUT TO INCLUDE A CHILLING EFFECT LETTER.	2
05/11/96;ODM	DRS/FREDRICKSON CLOSURE MEMO WITH ATTACHED: 1. ALLEGATION EVALUATION REPORT 2. REPORT NO. 96-07	5
07/16/96;ODM	DRS/BARR CLOSURE MEMO WITH ATTACHED: 1. ALLEGATION EVALUATION REPORT 2. REPORT NO. 96-04	3
07/26/96;ODM	SAC REVIEW, QA AMS AND FINAL CLOSURE	NONE
07/26/96;ODM	CASE CLOSED - OSCAR DEMIRANDA	NONE

E14

July 26, 1996

INDEX OF CONCERNS

ST LUCIE

RII-95-A-0183

NO.	DESCRIPTION	LOCATION
1/2	HEALTH PHYSICS CONCERNS INVOLVING POOR CONTROL OF CONTAMINATED TOOLS, LACK OF TRAINING FOR HEW HIRES, PERSONNEL CONTAMINATION EVENT,	Date:11/16/95 SAC ALLEG RPT
<p>ACTION: 12/07/96 ARB - DRS INSPT HP ISSUES IN CONCERN #1 WEEK OF FEB 26, 1995. DRS DEVELOP PLAN FOR REVIEWING SPEAK OUT TO INCLUDE A CHILLING EFFECT LETTER.</p>		
<p>CLOSURE: In summary, a non-cited violation and a cited violation were identified for failure to properly control contaminated tools. While some of the specific allegations were not substantiated, the CI identified a weakness in the licensee's controls for contaminated tools. This allegation is closed.</p>		
2/2	LACK OF MANAGEMENT RESPONSE TO CONCERNS AND EFFECTIVENESS OF SPEAKOUT	Date:11/16/95 SAC ALLEG RPT
<p>ACTION: 12/07/96 ARB - DRS INSPT HP ISSUES IN CONCERN #1 WEEK OF FEB 26, 1995. DRS DEVELOP PLAN FOR REVIEWING SPEAK OUT TO INCLUDE A CHILLING EFFECT LETTER.</p>		
<p>CLOSURE: The inspection report concluded that overall the NRC team inspection judged the Speakout program to be effective at all three company locations (Turkey Point, St. Lucie, and the Corporate Office in Juno Beach). It concluded that the company's Speakout program was effective in handling and resolving employee safety concerns. The teams review did not identify any technical issues that had not been adequately resolved.</p>		
3/		Date: __/__/__ Page: ____ para: ____
<p>ACTION:</p>		
<p>CLOSURE:</p>		

E/S

APRIL 20, 1995

Florida Power and Light Company
ATTN: Mr. J. H. Goldberg
President - Nuclear Division
P. O. Box 14000
Juno Beach, FL 33408-0420

SAFEGUARDS INFORMATION REMOVED

SUBJECT: NRC INSPECTION REPORT NOS. 50-335/95-08 AND 50-389/95-08

Gentlemen:

This refers to the inspection conducted by W. Tobin of this office on March 27 - 31, 1995. The inspection included a review of activities authorized for your St. Lucie facility. At the conclusion of the inspection, the findings were discussed with those members of your staff identified in the enclosed report.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

Within the scope of the inspection, violations or deviations were not identified.

The material enclosed herewith contains Safeguards Information as defined by 10 CFR Part 73.21 and its disclosure to unauthorized individuals is prohibited by Section 147 of the Atomic Energy Act of 1954, as amended. Therefore, the material will not be placed in the Public Document Room.

Should you have any questions concerning this letter, please contact us.

Sincerely,

original signed by
charles hosey for:

Douglas M. Collins, Chief
Nuclear Materials Safety and
Safeguards Branch
Division of Radiation Safety
and Safeguards

Docket Nos. 50-335, 50-389
License Nos. DPR-67, WPF-16

Enclosure: NRC Inspection Report
(Safeguards Information)

cc w/encl: (See page 2)

E/3

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UNITED STATES
 NUCLEAR REGULATORY COMMISSION
 REGION II
 101 MARIETTA STREET, N.W., SUITE 2900
 ATLANTA, GEORGIA 30323-0199

Report Nos. 50-335/95-08 and 50-389/95-08

Licensee: Florida Power and Light Company
 9250 West Flagler Street
 Miami, FL 33102

Docket Nos.: 50-335 and 50-389

License Nos.: DPR-67 and NPF-16

Facility Name: St. Lucie Plant Units 1 and 2

Inspection Conducted: March 27 - 31, 1995

Inspector: Walter J. Tobin
 W. Tobin, Senior Safeguards Inspector

4/18/95
 Date Signed

Approved by: D. McGuire
 D. McGuire, Chief
 Safeguards Section
 Nuclear Materials Safety and Safeguards Branch
 Division of Radiation Safety and Safeguards

4/20/95
 Date Signed

SUMMARY

Scope:

This routine, announced inspection was conducted in the areas of the Safeguards Program for Power Reactors. Specifically, the inspector reviewed Alarm Stations and Communications; Testing, Maintenance and Compensatory Measures; and Training and Qualification.

Results:

There were no violations identified. The inspector found Alarm Stations and Communications to be as required. Testing, Maintenance and Compensatory Measures appeared to be appropriate. Training and Qualification was a strength. The firearms range was exceptional, and, officers were professional and well versed on their duties and responsibilities.

Background investigations, which included psychological evaluation, were also part of this records verification.

The inspector visited the firearms range which was equipped with a classroom, lights, moving targets, a stress course and a "Shoot-Don't Shoot" course. Officers were observed in the conduct of initial qualification.

Several events relative to firearms were reviewed:

- o On November 19, 1994, a security officer, who was one of the several officers on duty at the North Security Building, was found to be wearing a weapon that did not have an ammunition magazine. This officer was equipped with two other magazines of ammunition. A search of the Building and of other areas and patrol routes taken by the officer failed to locate his missing ammunition magazine. The event was logged in the Safeguards Event Log, and a Security Incident Report was written.
- o On December 19, 1994, the Armory located within the East Security Building, inside the protected area, was unlocked and unattended for approximately two minutes. Inside this Armory are response weapons, body armor and ammunition. The event was documented in a Security Incident Report. An inventory accounted for all weapons and equipment. The Armory door is located across the hall from officers continuously posted inside the glass enclosure controlling access to the protected area. There is no requirements in the Physical Security Plan, nor implementing Security Procedures, that the Armory be locked when unattended.
- o On March 6, 1995, a training weapon (unusable due to the firing pin having been removed) was found to be missing from the Security Response Room inside the protected area. The weapon had been accounted for earlier in the shift during an inventory. An extensive search of all relative areas, posts and vehicles did not locate the weapon. The local St. Lucie County Sheriffs Department was notified and interviews, using a voice stress analyzer, were initiated with all officers involved with the weapon. A Lieutenant found the weapon in a trash can on March 12 outside the protected area near the door to the contract security offices. The event was originally "Red Phone" to the NRC but was downgraded to a Safeguards Event Log item.
- o On March 16, 1995, a five round magazine of 45 caliber ammunition was found inside a briefcase carried by a licensee supervisor prior to entering the protected area. A Security Information Report was written. Since there was no malevolent intent, there was no Safeguards Event



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

MAY 11, 1996

MEMORANDUM FOR: Oscar DeMiranda, Senior Regional Allegation Coordinator
Enforcement and Investigation Coordination

FROM: Paul E. Fredrickson, Chief
Special Inspection Branch
Division of Reactor Safety

SUBJECT: CLOSEOUT OF ALLEGATIONS
ST. LUCIE (SPEAKOUT RELATED PORTIONS OF ALLEGATION NOS.
RII-A-95-0065, RII-A-95-0154, RII-A-95-0183, RII-A-95-0186)
ANONYMOUS MISCELLANEOUS ALLEGATIONS

The scope and circumstances of the Speakout portions of anonymous allegations RII-A-95-0065, RII-A-95-0154, RII-A-95-0183, and RII-A-95-0186 were reviewed by an NRC team inspection conducted on site April 29 - May 3, 1996 (Reference IR 50-335,389/96-07). Attachment 1 to this memo, Allegation Evaluation Report (AER), contains information about the results of this inspection and review of the allegations. Also included in the AER is the inspector's findings and conclusions. Attachment 2 contains a copy of the Inspection Report Nos. 50-250,251/96-05 and 50-335,389/96-07.

The allegations were not substantiated. However, some elements of the statements made by the allogers were noted in the inspection report as a concern to the NRC and were discussed with the licensee and documented in the subject inspection report. It is recommended that the Speakout related issues in these case files be closed.

Attachments: 1. Allegation Evaluation Report
2. Inspection Report Nos. 50-250,251/96-05 and 50-335,389/96-07

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ALLEGATION EVALUATION REPORT

Turkey Point Nuclear Plant
St. Lucie Nuclear Plant
Juno Beach Corporate Offices

Docket Nos. St. Lucie 50-335 and 389
Turkey Point 50-250 and 50-251

ANONYMOUS ALLEGATIONS

RII-A-95-0065, RII-A-95-0154, RII-A-95-0183 and RII-A-95-0186

ALLEGATION:

Numerous anonymous allegation sent to the NRC Region II Office alleged concerns about the Florida Power & Light Nuclear facilities. The allegations are not specific but alleged the following broad concerns:

- Management gets rid of employees that bring up problems or go to "Speakout"
- Employees bring up concerns to "safety" and nothing get done
- Speakout is a joke, worthless, a coverup program
- Within minutes of going to "Speakout" everyone knows
- When NRC talks to workers, NRC needs to do so without management knowing who is being interviewed
- Upcoming cutbacks by utility president threatens safety

DISCUSSION:

The NRC determined the above subject anonymous allegations did not have enough specific details for NRC to do detailed inspections. Further, the allegers are anonymous, thereby preventing the NRC from obtaining additional information from the specific allegger. In order for the NRC to address these broad statements, an NRC team inspection (IR 50-250/96-05, 50-251/96-05, 50-335/96-07, and 50-389/96-07) was performed at Turkey Point, St. Lucie, and Juno Beach facilities on April 22 through May 3, 1996. The inspection evaluated the adequacy of the Speakout programs at those facilities and included interviews with various on-site disciplines, including utility management and detailed record reviews of site specific allegation closure files. The objective of the inspection was to evaluate the effectiveness of the utilities ability to address safety issues and protect the identify of the concerned employee.

ATTACHEMENT 1

Conclusion:

The inspection report concluded that overall the NRC team inspection judged the Speakout program to be effective at all three company locations (Turkey Point, St. Lucie, and the Corporate Office in Juno Beach). It concluded that the company's Speakout program was effective in handling and resolving employee safety concerns. The teams review did not identify any technical issues that had not been adequately resolved.

The team did note that recent staffing reductions and a perceived lack of employee confidence associated with identity protection; may have negative effects on the program in the future. The team also noted that investigative techniques and methods used by the licensee when investigating specific concerns and making corrective action recommendations have the potential to inadvertently identify the concerned individual. Additionally, the team noted the licensee's feedback policy to the concerned individual lacked specific details on the outcome of the employees concern. This lack of information could lead to apprehension on the part of the alleger and subsequently result in the alleger concluding that nothing was done about his or her safety issue which could be contrary to the actual corrective actions taken by the licensee.

Recent staffing reductions affected the job status of some employee's that had previously gone to the Speakout program. This potentially led employee's to the conclusion that because they had gone to speakout with a concern that they had been terminated or gotten rid of.

The team also noted the resolution and closure of employee concerns was not always done in a timely manner. This also had the potential to incorrectly lead the concerned employee to the conclusion that his concern was not important and not acted upon by the Speakout group. The team found that although some of the issues were not resolved in a timely manner, all issues were adequately eventually resolved.

Separate from the team inspection, an NRC review was performed of FP&L employee concern file number NSS-PSL-95-044. The employee concern file stated that: "Employee's go to Speakout, are tagged as troublemakers and laid off. Program also prevents issues from going to the NRC. This information was received by the licensee in an anonymous letter to J. H. Goldberg (former Nuclear Division President) on October 30, 1995. The licensee had completed this investigation by obtaining from Human Resources a list of FPL/PSL employees who, for whatever reason are no longer employed at PSL for the years 1992, 1993, 1994, 1995 and to date, 04/01/1996. They then reviewed the list against employee's that had gone to Speakout and expressed a concern (by name) since the Speakout program was implemented in March of 1990.

The licensee's review found that from 01/01/1992 to 04/01/1996, 279 FPL employees have exited the PSL site (temporary employee and students employed during the summer were not included in the 279 figure). The records revealed that 25 of the 279 employee's that had left PSL, had at some time expressed a concern to the employee's concern Speakout program. However, none of the 279

had expressed any concern, including their exit interview, that they believed they were terminated because they had previously gone to the Speakout program. The licensee concluded that no evidence was identified that any employee had been released from employment at PSL because he had expressed a concern to Speakout. Further, the licensee concluded from the record review that no employee had made any such statement to the licensee when they left PSL employment. The record file indicates the licensee was unable to substantiate this anonymous statement.

The licensee also reviewed the Speakout files of all employees (contractors, and temporary employees) who exited the PSL plant since 1990. Approximately 6,000 employees exited the PSL plant since 1990. The licensee's review found that no employee who had exited during this time frame expressed a concern that their termination for any reason, was related to having expressed a concern to Speakout.

Regarding the statement that the Speakout program prevents issues from going to the NRC, the licensee concluded that all employees who are badged at PSL are apprised of the purpose of the Speakout program in their initial training/orientation to the site. This training is mandatory and a video is shown that encourages employees to take safety concerns they may have to their supervisor, the Speakout program, or the NRC. Additionally, an annual refresher/requalification is mandatory for all employees and in the training, the employees are again reminded of the Speakout program and encouraged to express their concerns to management, Speakout or the NRC. The licensee was unable to find any evidence that supports the theory that issues are prevented from going to the NRC.

The NRC inspectors reviewed the licensee's evaluation, including a review of the list of employees that left PSL employment since 1990 and found the evaluation provided adequate justification to support their conclusion that employees are not being released from the site because they went to the Speakout program and expressed a safety concern. The inspector also concluded that issues are not being prevented from going to the NRC because of the Speakout program. However, most issues are being properly resolved by Speakout which necessitates the need for issues coming to the NRC. The inspector concluded the licensee had adequately addressed this anonymous allegation.

The NRC's review of the anonymous allegations concluded that without more specific information, no further review of these concerns are required. The team inspection determined from employee interviews that employees would use the Speakout program if they had a safety issue that was not adequately resolved by their management. Further, the team determined from sample reviews of closure files that safety issues that go to the Speakout program are being adequately resolved. Some concerns were identified in the IR which the licensee should address and correct. The Speakout portion of the anonymous allegations listed above are considered closed.

April 29, 1996

Florida Power & Light Company
ATTN: T. F. Plunkett
President - Nuclear Division
P. O. Box 14000
Juno Beach, Florida 33408-0420

SUBJECT: NRC INTEGRATED INSPECTION REPORT NOS. 50-335/96-04 AND
50-389/96-04 AND NOTICE OF VIOLATION

Gentlemen:

This refers to the inspection conducted on February 18 through March 30, 1996, at the St. Lucie facility. The purpose of the inspection was to determine whether activities authorized by the license were conducted safely and in accordance with NRC requirements. At the conclusion of the inspection, the findings were discussed with those members of your staff identified in the enclosed report.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

Based on the results of this inspection, the NRC has determined that violations of NRC requirements occurred. The violations are cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding them are described in detail in the subject inspection report. The violations are of concern because they indicate that personnel performance with respect to procedure compliance and usage and attention to detail persist even after corrective actions had been completed for previous, similar, violations. Particularly illustrative of this point is a violation for failures associated with the Unit 1 containment particulate/iodine/gaseous radiation monitor. The event displayed particularly poor performance on the part of several individuals and included aspects of failing to access and follow a procedure, compounded by failing to capitalize on multiple opportunities to identify the inoperable component through logtaking. Logtaking weaknesses were further compounded by the fact that non-licensed operators taking the logs were electronically prompted that a key parameter associated with the component's operability was unacceptably low. The failure to pursue this condition, with at least six logtaking opportunities, indicates that a lack of a questioning attitude extends to multiple personnel. It is also noted that a failure to employ an approved procedure lead to a condition of Emergency Diesel Generator inoperability (the subject of another violation in the enclosed report).

As documented in the report, we have performed an initial review of the Licensee Event Report you submitted for the subject event. While we found your immediate corrective actions appropriate, we question the scope of the actions delineated in your transmittal. Consequently, in your response to the enclosed Notice, please describe what actions you will take to instill, in non-licensed operators, an understanding of the vital role they play in the

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early detection of off-normal conditions during logtaking and log review. Additionally, please describe your basis for believing that other cases of inoperability in components have not been overlooked through similar errors and any actions you have taken (or plan to take) to identify those components which may be rendered inoperable in a similar manner (by non-Operations personnel performing routine evolutions for which the control room may not have cognizance). Please plan to discuss the progress of your corrective actions at the next FPL/NRC management meeting scheduled for June 12, 1996.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be placed in the NRC Public Document Room (PDR). 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.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Should you have any questions concerning this letter, please contact us.

Sincerely,

Orig signed by Kerry D. Landis

Kerry D. Landis, Chief
Reactor Projects Branch 2
Division of Reactor Projects

Docket Nos. 50-335, 50-389
License Nos. DPR-67, NPF-16

Enclosures: Notice of Violation
Inspection Report

cc w/encl: (See page 2)

cc w/encl:

W. H. Bohlke, Site Vice President
St. Lucie Nuclear Plant
P. O. Box 128
Ft. Pierce, FL 34954-0128

H. N. Paduanu, Manager
Licensing and Special Programs
Florida Power and Light Company
P. O. Box 14000
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Joe Myers, Director
Division of Emergency Preparedness
Department of Community Affairs
2740 Centerview Drive
Tallahassee, FL 32399-2100

cc w/encl: See page 3

NOTICE OF VIOLATION

Florida Power & Light Company
St. Lucie 1

Docket Nos. 50-335
License Nos. DPR-67

During an NRC inspection conducted on February 18 through March 30, 1996, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381; June 30, 1995), the violations are listed below:

- A. Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2, February, 1978. Appendix A, paragraph 1.33.1 includes administrative procedures for procedural adherence. Q1 5-13, PSL-1, Rev 68, "Preparation, Revision, Review/Approval of Procedures," Section 5.13.1, states that all procedures shall be strictly adhered to.

Step 7.5.1.R of procedure HPP-22, Rev 2, "Air Sampling," required that valve 3 of the Unit 1 containment Particulate Iodine Gaseous Monitor be returned to the open position following the performance of a containment grab sample.

AP 0010120, Rev 79, "Conduct of Operations, Appendix F, "Log Keeping," required, in part, that "Log readings shall be compared to previous readings to detect abnormal trends or conditions and verified to be within the minimum and maximum values for that parameter. All log readings outside the min/max values shall be circled with reasons stated for abnormal readings (i.e., OOS, NPWO, ISOL, etc)."

Contrary to the above:

1. On February 22, 1996, a health physics technician performing a grab sample of the Unit 1 containment failed to return valve 3 to the open position and, as a result, rendered the monitor inoperable.
2. On February 22, 23, and 24, 1996, Senior Nuclear Plant Operators failed to perform adequate reviews of logs taken in the Unit 1 Reactor Auxiliary Building, as the out-of-specification log readings taken on the Unit 1 containment particulate iodine gaseous monitor were not highlighted and explained. As a result, the Unit 1 containment Particulate Iodine Gaseous monitor remained inoperable and Unit 1 transitioned from Mode 3 to Mode 2 without satisfying Technical Specification Limiting Condition for Operation 3.4.6.1. The Mode transition was prohibited by Technical Specification 3.0.4.

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

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- B. Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2, February, 1978. Appendix A, paragraph 1.d includes administrative procedures for procedural adherence. QI 5-PR/PSL-1, Rev 68, "Preparation, Revision, Review/Approval of Procedures," Section 5.13.1, states that all procedures shall be strictly adhered to.

AP 0010120, Rev 80, "Conduct of Operations," Appendix F, "Log Keeping," required, in part, that reactivity manipulations be entered in the Reactor Controls Operator Chronological Log.

AP 0010120, Rev 80, "Conduct of Operations," Appendix F, "Log Keeping," required, in part, that abnormal conditions in turbine-generator auxiliary systems be entered in the Reactor Controls Operator Chronological Log.

Contrary to the above:

1. On March 27, 1996, St. Lucie Unit 1 operators performed two Reactor Coolant System dilutions (reactivity manipulations), which were not entered in the Reactor Controls Operator Chronological Log.
2. On March 27, 1996, hydrogen was added to restore a low pressure condition in the St. Lucie Unit 1 generator and was not entered in the Reactor Controls Operator Chronological Log.

This is a Severity Level IV violation (Supplement I)

- C. Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev 2, February, 1978. Appendix A, paragraph 1.d includes administrative procedures for procedural adherence. QI 5-PR/PSL-1, Rev 68, "Preparation, Revision, Review/Approval of Procedures," Section 5.13.1, states that all procedures shall be strictly adhered to.

OP 1-2200050A, Rev 24, "1A Emergency Diesel Generator Periodic Test and General Operating Instructions," Appendix E required, in part, that the 1A Emergency Diesel Generator Fuel Oil Storage Tank be recirculated by establishing a flow path from the tank, through the transfer pump, and through valves V17207 and V17208 back to the tank.

QI 1-PR/PSL-2, Rev 26, "Operations Organization," and AP 0010120, Rev 79, "Conduct of Operations," Appendix A, required that Senior Nuclear Plant Operators "...report promptly to the Control Room any equipment or valve manipulations so that the RCO will be aware of the current plant status."

Contrary to the above:

1. On January 5, a Senior Nuclear Plant Operator placed the 1A Emergency Diesel Generator Fuel Oil Storage Tank in recirculation by isolating the discharge of the transfer pump and allowing the fuel to be recirculated back to the tank via the pump's minimum flow line. The isolation of the transfer pump's discharge resulted in the Emergency Diesel Generator being inoperable.
2. On January 5, a Senior Plant Nuclear Operator failed to notify the Unit 1 control room of a valve manipulation made to place the 1A Emergency Diesel Generator on recirculation.

This is a Severity Level IV violation (Supplement I)

- D. 10 CFR 50, Appendix B, Criterion XI, "Test Control," requires in part that a test program be established to assure that all testing required to demonstrate that components will perform satisfactorily in service and that test results be evaluated to assure that test requirements have been satisfied. FPL Topical Quality Assurance Report 11.0, Rev 4, "Test Control," step 11.2.3, "Evaluation of Test Results," requires that "...documented test results shall be evaluated against the predetermined acceptance criteria by a group or individual having appropriate qualifications."

Contrary to the above, on May 22, 1993, the licensee failed to adequately evaluate Unit 1 CEDM coil resistance test results to assure that test requirements were satisfied as specified in PWO 63/0046 for PC/M 133-191. This resulted in not identifying and dispositioning 11 CEDMs coils whose resistance readings did not meet the specified item #11, Acceptance Criteria of Attachment 4, "PC/M Testing Document."

This is a Severity Level IV violation (Supplement I)

Pursuant to the provisions of 10 CFR 2.201, the Florida Power & Light Company is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region II, and a copy to the NRC Resident Inspector at the facility that is the subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violations, or, if contested, the basis for disputing the violations, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

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 reduction. However, if you find it necessary to include such information, you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at Atlanta, Georgia
this 29th day of April 1996.



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0180

U.S. NUCLEAR REGULATORY COMMISSION
REGION II

Docket Nos: 50-335, 50-389
License Nos: DPR-67, NPF-16

Report No: 50-335/96-04, 50-389/96-04

Licensee: Florida Power & Light Co.

Facility: St. Lucie Nuclear Plant, Units 1 & 2

Location: 9250 West Flagler Street
Miami, FL 33102

Dates: February 18 - March 30, 1996

Inspector: Edward Miller, Sr. ^{10/15/96} 4/28/96
M. Miller, Sr. Resident Inspector Date Signed

Accompanying Inspectors:

S. Sandin, Resident Inspector
M. Thomas, Reactor Inspector, paragraph M2
F. Wright, Reactor Inspector,
paragraphs R1, R3, R5, R6, R7, and R8
R. Chcu, Reactor Inspector,
paragraphs 1.2.1 through 1.2.4
E. Lea, Project Engineer,
paragraphs 04.2, 04.4, M8.2, M8.3, and M8.4
J. Coley, Reactor Inspector,
paragraphs M1.2.5 through 1.2.10 and M3.2
J. Moorman, License Examiner, paragraphs 04.3
and 05

Approved by: K. Landis 4/29/96
K. Landis, Branch Chief Date Signed
Division of Reactor Projects

EXECUTIVE SUMMARY

St. Lucie Nuclear Plant, Units 1 & 2
NRC Inspection Report 50-335/96-04, 50-389/96-04

This integrated inspection included aspects of licensee operations, maintenance, and plant support. The report covers a 6-week period of resident inspection; in addition, it includes input from regional inspectors in the areas of Maintenance and Plant Support.

Operations

- Operators performed well during a Unit 1 dropped CEA event on February 22. Response to the transient, declaration of an Unusual Event, and a manual reactor trip (inserted when feedwater anomalies were identified) were all timely and appropriate.
- On March 4, while a Unit 1 MTC test was being conducted, CEA #1 was declared inoperable during installation and removal of test equipment with no Equipment Out-Of-Service Log entry made (NCV 50-335/96-04-08, "Failure to Log an OOS CEA in the Equipment Out-Of-Service Log").
- The return to power of Unit 1 was complicated by an attempt to synchronize to the grid with the main generator disconnects open. An inadequate procedure was the root cause (NCV 50-335/96-04-07, "Inadequate procedure leads to switchyard misalignment").
- Walkdowns of both units' Containment Spray systems resulted in the identification of a number of procedural, drawing and hardware deficiencies. Based on the number of deficiencies identified the inspectors expanded the scope of the detailed walkdowns to include the Intake Cooling Water System of both units. At the close of the inspection period the reviews were not complete. The issue will be tracked as an unresolved item (URI 96-04-05, "Configuration Control Management").
- Control room observations resulted in the identification of:
 - a failure to employ a procedure for boric acid addition (an additional example of a previous violation - VIO 96-03-01)
 - failures to make required log entries for reactivity manipulations and a main generator hydrogen addition (VIO 96-04-02)
- A containment gaseous/particulate/iodine monitor was rendered inoperable due to a failure to follow procedures, combined with a lack of proper follow through on the part of non-licensed operators taking logs (VIO 96-04-01).
- An Emergency Diesel Generator was rendered inoperable due to a failure to follow procedures while placing the fuel oil tank on recirculation (VIO 96-04-03).
- The requalification program is supporting management expectations for operations and covering timely and important topics.

- The Unit 1 TS 3.6.2.2.a and the UFSAR Table 6.2-22 is inconsistent with respect to NaOH concentration. Pending further NRC review, failure to update the UFSAR is an unresolved item (URI 50-335,389/96-04-09, Failure to Update UFSAR).

Maintenance

- The procedures used for testing and maintenance on a number of observed maintenance activities were adequate to provide the details for the craft to perform maintenance, inspection, and calibration. The crafts were knowledgeable and skillful in doing work. The inspectors were satisfied with the work performed. However, one weakness was observed for a crew not signing and dating the working copy of the Work Order in the field prior to physically starting work.
- A review of maintenance procedure revision control indicated that the licensee's program contained vulnerabilities which could result in the wrong revision to a given procedure being used in the field. The licensee's corrective actions were satisfactory.
- The Lack of a preapproved structured troubleshooting plan for a CEA problem, especially considering the short TS AOT involved, was considered a weakness.
- There were weaknesses noted in the licensee's maintenance program relative to the SBCS valves and MFRV.
- Reviews of historical data for CEA maintenance revealed that post-modification testing acceptance criteria for Unit 1 CEA power cables were not applied to post-modification test data (VIO 96-04-04).
- Closeout of an Unresolved Item concerning poor HP work practices exhibited by maintenance personnel resulted in a non-cited violation for failure to adhere to Radiation Work Permit requirements (NCV 96-04-05)

Engineering

- The engineering disposition for a deficiency identified in Unit 1 Boroflex panel length was reviewed and found to be satisfactory.

Plant Support

- Based on interviews with licensee staff, record reviews, and observations made during tours of licensee facilities; the inspector found the RP program to be adequately managed and internal and external exposure control programs were effectively implemented with all radiation exposures within 10 CFR Part 20 limits. One non-cited violation was identified concerning failure to follow procedures for the control of contaminated tools utilized in the licensee's radiological control area (NCV 96-04-06).

- The permanent modifications for cooling Unit 2 Containment Building in 1995 was a positive step in increasing worker efficiency and reducing collective outage dose and number of personnel contamination events. The modification demonstrated managements commitment to worker safety, RP and ALARA.
- Unplanned maintenance activities and rework significantly increased outage work in 1995 and was the primary reason the licensee exceeded its 1995 annual collective dose goal of 283 person-rem by approximately 129 person-rem. This was basically a maintenance and operations problem adversely impacting the station ALARA program.

IV. Plant Support

R1 Radiological Protection and Chemistry (RP&C) Controls (83750)

R1.1 External and Internal Exposure Controls

This program area was reviewed to evaluate the adequacy of licensee RP controls for internal and external radiation hazards and to verify individual radiation doses did not exceed the dose limits described in Subpart C, of 10 CFR Part 20.

Selected elements of the licensee's personnel exposure control program were reviewed. Based on direct observation, review of records and discussions with licensee personnel the inspectors noted the following:

- Reviewed RWP's provided adequate RP instructions and controls;
- Personnel monitoring equipment was utilized appropriately;
- Locked high radiation areas were properly posted and secured; and
- Process and engineering controls to limit exposures to airborne radioactivity were considered and utilized when possible.

The licensee reported the following maximum doses (Rems) for individuals in calendar year 1995 and 1996 to date:

Year	TEDE	Skin	Extremity	Lens-Eye
1995	2.263	2.452	2.452	2.263
1996	0.254	0.258	0.258	0.254
Part 20 Limits:				
	5.000	50.000	50.000	15.000
Adm. Limits:				
Site	2.500	25.000	25.000	7.500
Total	4.500	45.000	45.000	13.500
1996 data through February 26, 1996.				

In 1995, the highest individual CDE dose assigned was 287 mrem and the highest CEDE dose assigned was 33 mrem. No individual internal exposures had been identified at the time of the inspection for 1996. All external and internal exposures were well within the regulatory limits.

The licensee has applied for NVLAP certification of its electronic dosimeter program. The licensee has completed performance testing in

categories II, IV, and VI.b. and passed in categories IV and VI.b. The licensee did not plan to re-test in category II, an accident category since the licensee did not plan to use the electronic dosimeters as the primary dosimeter for emergency response. The licensee had already received its on site review and expected certification of the electronic dosimetry program in 1996. The licensee has been conducting parallel testing of TLDs and electronic dosimeters for approximately two years. The licensee expects to keep the TLD as the dose of record, at this time. The licensee planned to continue using TLDs for special monitoring conditions such as high beta dose component fields or neutron fields. The on-going work in obtaining accreditation of the FPL electronic dosimetry program was identified as a good example of the health physics program technical capabilities.

Through review of licensee procedures and reported dose information, the inspector concluded the licensee was implementing adequate RP controls and monitoring individual occupational radiation exposures in accordance with the requirements and that all individual doses reported were within 10 CFR Part 20 limits.

No violations or deviations were identified.

R3 RP&C Procedures and Documentation (83750)

R3.1 Control of Radioactive Materials and Contamination, Surveys and Monitoring

This area was reviewed to evaluate the licensee's control of radioactive and contaminated material.

St. Lucie TS 6.8.1 required written procedures be established, implemented and maintained covering the activities recommended in Appendix A of RG 1.33, Rev 2, dated February 1978. RG 1.33, Appendix A, 1978, required written procedures for contamination control.

The inspector reviewed the licensee's procedures for the control of tools within the licensee's RCA. St Lucie HPP- 41, Rev 1, "Movement of Material and Equipment," dated September 29, 1994, described the licensee's procedures for positive control of materials and equipment located in and leaving the RCA. Section 7.5 of HPP-41 addressed the use of tools and equipment in the RCA. Step 7.5.2 stated "Paint contaminated tools and equipment designated for use in the RCA with purple paint." Step 7.5.3 stated, in part, "Unless otherwise authorized, use only those tools that meet the following criteria for fixed and removable radioactivity:

Beta-Gamma < 10 mrem/hr Fixed and
< 1,000 dpm/100 cm² Removable."

During a tour of the licensee's RCA the inspector noticed maintenance workers working on some equipment in the Hot Tool Room. The inspector

inquired about the workers activities and learned the equipment was not from any contaminated system. While there, the inspector observed several maintenance workers searching for various tools and observed one worker returning tools to the storage cabinets. The worker returning tools reported the tools had not been used. The inspector noted the Hot Tool Room was a self-serve facility and that there appeared to be little control of materials or tools entering or leaving the room. Many workers left the tool room without the tools they had been looking for and the inspector noted some of the tool bins were empty.

The inspector made independent radiation and contamination surveys of the items stored there. During the survey the inspector found numerous tools that were not painted with purple paint and 2 tools exceeding the contamination levels for such tools. One tool having approximately 14 mrem/hr beta gamma exceed the fixed beta gamma contamination limit of 10 mrem/hr and another set of jacking bolts having contamination levels of approximately 1,500 dpm/100 cm² exceeded the removable contamination limit of 1,000 dpm/100 cm². The inspector identified the tools to a health physics technician and they were promptly removed from the Hot Tool Room for decontamination. The inspector stated that failure to paint tools utilized in the RCA with purple paint and failure to control tools having radiation levels in excess of licensee procedure limits appeared to be violations of licensee procedure requirements. The finding constitutes a violation of minor significance and is being treated as a NCV, consistent with Section IV of the NRC Enforcement Policy.

NCV 50-335,389/96-G4-06: Violation of TS 6.8.1 requirements for failure to follow contamination control procedures for the control and use of contaminated tools in the RCA.

In order to provide better control of these tools, licensee representatives reported that there would be a worker assigned to the Hot Tool Room for half a day on day shifts and the tool room would be locked at all other times.

The inspector also requested and observed surveys of selected tools in the licensee's Clean Tool Room. No contaminated tools were found during those surveys.

The inspector toured the yard and individual buildings in the RCA and noted that there appeared to be more contaminated material stored within the RCA than the inspector had observed at the site on previous RP inspections. The inspector determined that some of the additional material was material that had not been decontaminated following the 1995 outages. The problems with the Hot Tool Room and the amount of contaminated material accumulating around the site appeared to be related to the significant cuts in the numbers of utility workers on site during and following the most recent outages. The inspector reported to licensee management that continued attention was needed to reduce the amount of radioactive material and contaminated material the licensee had stored in yard and warehouses. Licensee representatives

reported temporary personnel would be hired during the next few months to reduce the backlog of contaminated material.

Housekeeping in the Auxiliary Buildings was generally good. However process areas such as the decontamination facility and equipment storage areas such as the one near the Unit 1 personnel access hatch were cluttered and untidy. No uncontrolled containers of radioactive material or contamination were identified.

At the time of the inspection the licensee reported there were only 250 ft² of contaminated area in the licensee's decontamination plan, which included 106,063 ft². The plan excluded the Containment Buildings and certain process areas such as the decontamination facility. The 250 ft² was the lowest level obtained by the licensee in recent years.

The inspector reviewed documentation of selected PCEs and annual PCE trends. The inspector noted that the licensee had approximately 83 PCEs in 1995 which exceed the goal of 50 PCEs. The number of outage days in 1995, approximately 170, was the primary reason the licensee had exceeded this goal. The licensee actually had fewer PCEs in 1995 than in 1994. The licensee had 95 PCEs in 1994 with approximately 104 outage days. The licensee documented PCEs at a threshold of 100 cpm above background, measured with a thin window GM detector. The inspector noted the licensee surveyed the walkways in the Auxiliary Buildings daily with large swipes which helped in reducing the number of PCE occurring in clean areas. No concerns with PCEs were identified during the inspection.

The inspector observed several empty drums in the RCA and inquired about the licensee's procedures for releasing empty drums having once contained hazardous material or used oil. The inspector learned that drums containing a hazardous material and radioactive contamination were not released and were stored within the RCA. Fifty-five gallon drums of hazardous material free of radioactive contamination and exiting the RCA were stored on a special pad on the secondary side of the facility. Used oil leaving the RCA which could have been exposed to radioactive contamination was sampled and analyzed for uncontrolled release.

The inspector determined that used oil from the site was collected in a holding tank for offsite processing. The inspector also learned that the licensee had processors for separating water from oil which were located on the secondary side of the facility in the Turbine Buildings. The separated oil from an oil and water mixture was transferred to the oil holding tank and the separated water was released to the yard drainage system which emptied into evaporation/percolation ponds located within the protected area.

The inspector noted that the east pond was posted with signs displaying a radiation symbol and the words: "Restricted Area Keepout" and "Radioactive Materials Area." The inspector determined that the east pond had received some contaminated water from a spill in 1977. The inspector learned that in 1992 the licensee had sampled and evaluated

the soil from the pond berm and bottom. At that time, detectable radioactive contamination was observed at various depths of 1-6 feet with the activity decreasing with depth. The most significant level of contamination detected was in the first three feet of sediment below the pond with radioactive concentrations of $1.5E-6$ micro-Ci/g of Cs-137 and $2.4 E-6$ micro-Ci/g of Co-60. Licensee representatives reported that the water was currently free of measurable contamination. The inspector observed several species of fowl utilizing the pond during the inspection. No concerns with the removal of drums from the primary to secondary side of the facility were identified.

One NCV and no deviations were identified.

R5 Staff Training and Qualification in RP&C (83750)

R5.1 Training

This area was reviewed to verify that site health physics technicians were receiving continuing training.

Through interviews with licensee personnel, review of licensee training documents and training records the inspector determined that the licensee was providing continuing training for health physics technicians. The licensee provided approximately 37 hours of continuing training for health physics technicians in 1995 and expected to provide approximately that amount in 1996. However, the licensee had not developed a schedule for proposed training. The inspector noted the 1995 training provided was appropriate for continuing health physics technician training. The inspector determined the technicians generally found the quality of the training good and useful for their responsibilities.

No violations or deviations were identified.

R6 RP&C Organization and Administration (83750)

R6.1 Occupation Radiation Exposure Control Program Changes

Changes in the RP program, since the last inspection, were reviewed to assess their impact on the effective implementation of the RP program. The inspection focused on changes in organization, personnel, facilities, equipment, programs, and procedures. The previous RP inspection was conducted during the period of May 30 through June 2, 1995. With the exception of organizational changes described below the licensee had not made any significant changes in the RP program.

The site health physics department lost several positions in down-sizing activities in February 1996. The number of site senior health physics technicians was reduced from 32 to 30 and 2 health physics supervisor positions were also eliminated. The most significant change in numbers of staff reductions was the decline in decontamination workers from 22 to 12.

The responsibilities held by the Special Project Material Condition Supervisor and Instrumentation Supervisor were temporarily transferred to the ALARA Supervisor and the Radioactive Waste Supervisor respectively. The inspector did not identify any concerns with the licensee's changes in organization structure or in the qualifications of personnel receiving new program responsibilities. While the loss of the two supervisors reduced collective staff expertise it did not appear that the changes would adversely affect the licensee's programs for control of radiation exposures and radioactive materials.

No concerns were identified with the reductions in the number of health physics technicians. The decontamination workers reductions did appear to have a negative impact on the quantity of contaminated material the licensee had stored around the facility (Paragraph R3.1). However, no violations of regulatory requirements concerning the control of radioactive material were identified during the inspection.

The organization chain of command structure from the site Health Physics Supervisor to the Operations Manager to the Plant General Manager had not changed. However, recent changes in personnel were made for the Operations Manager and the Plant General Manager positions.

There were also decreases in the number of vendor personnel supporting site health physics activities in 1995. The number of senior health physics technicians decreased from 69 in 1994 to 51 in 1995. Other decreases from 1994 levels to those in 1995 included: junior health physics technicians from 41 to 18; dosimetry technicians from 16 to 13; and decontamination personnel from 53 to 44. Additional decreases in the numbers of vendor support personnel during outages were not expected in 1996. However, the licensee planned to bring in the personnel as needed and did not plan to use the personnel throughout the entire outage.

No violations or deviations were identified.

R7 Quality Assurance in RP&C Activities (83750)

R7.1 Audits

Audits of RP activities were reviewed to determine the adequacy of the licensee's identification and corrective action programs for deficiencies or weaknesses related to the control of radiation or radioactive material.

The inspector reviewed the licensee's 1995 and 1996 audits of RP program activities. Reviews of RP activities during this period were limited to several performance monitoring activities which the licensee referred to as PMONs. Five PMONs were conducted in the RP area in 1995 and two were on-going during the inspection for 1996. The inspector also reviewed the checklist and auditor notes for each of the 1995 PMONs. One finding requiring corrective actions was identified in the five PMONs and the inspector verified it's corrective actions were proceeding.

The inspector determined that the licensee was reviewing the RP program and tracking audit findings for correction. No concerns with the licensee's audit program, findings or corrective actions were identified.

No violations or deviations were identified.

RB Miscellaneous RP&C Issues (83750)

RB.1 Maintaining Occupational Exposures ALARA

This program area was reviewed to determine the status and effectiveness of ALARA program initiatives in reducing collective dose for the site. Areas reviewed included site annual and outage goals and objectives, and the collective dose results.

A summary of recent collective dose and goals for the site is shown below.

Collective Personnel Exposures (Person-Rem)						
	Annual Dose		Title	Outage Dose		Days
	Actual	Goal		Actual	Goal	
1993	460	477	U2-SNO	71	-	77
			U1-RFO	387	444	61
			U1-SNO	55	-	12
1994	505	600	U2-RFO	168	187	71
			U1-RFO	290	361	33
1995	412	283	U1-SNO	18	-	8
			U1-SNO	41	-	80
			U2-RFO	311	172	83
1996	7	356	U1-RFO	-	-	-

Notes:

The 1996 dose information was measured with electronic dosimeters and was current through February 26.

The 1996 U1-RFO outage goals had not been issued.

Unplanned outages, maintenance activities and re-work were the primary reasons the licensee exceeded the 1995 annual collective dose goal of 283 person-rem by approximately 129 person-rem. This was basically a maintenance and operations problem which significantly and adversely

impacted the station ALARA program. The duration of the U2 RFO was expected to be 53 days and actually lasted approximately 83 days due to expanded work scope and rework. The licensee also had an extended outage on U1 of approximately 80 days. Even with the increased work load, the 1995 annual collective dose was the lowest since 1992 when the licensee had 245 person-rem.

The site collective dose goal for 1996 had just been approved by plant management. The ALARA staff had identified four possible site collective dose goals for management consideration. The goals considered such factors as industry averages and historical performance. Upper management selected the most challenging one at 356 person-rem.

The licensee had just started a new ALARA Man-Rem Budget program similar to one utilized at Turkey Point. At the time of the inspection the plan had just been approved and little use of the system had been made. The plan assigned a dose budget for each department and the departments were required to complete assigned responsibilities without exceeding their allotted dose budget. An element of the plan permitted departments to borrow dose from one another as needed. The licensee expects the implementation of the process to result in increased involvement of the St. Lucie staff in dose reduction solutions.

The licensee completed a permanent modification on U2 Containment Building in 1995 which provided air conditioning to the building during outages. The licensee planned to make the same modification on U1 during the 1996 RFO scheduled for Spring 1996. The licensee had found that air conditioning had generally increased worker efficiency and safety and had resulted in fewer PCEs from leaching protective clothing. The air conditioning modification was an example of licensee management's support for personnel safety, RP and ALARA programs.

The inspector also learned the licensee had started preliminary preparations for a U1 SG replacement project scheduled for January in 1998.

Based on direct observation, discussion and review of records the inspector concluded the licensee was utilizing ALARA techniques and making progress in reducing collective doses for the staff. However, the recent failure to meet 1995 annual collective dose goal indicated additional attention to reduce collective doses during outages was needed.

No violations or deviations were identified.

P4 Staff Knowledge and Performance in EP (71750)

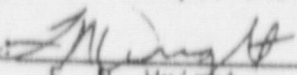
On January 22, at approximately 7:45 p.m., Unit 2 began a downpower from 100 percent to 90 percent in preparation for turbine valve testing. During the downpower, I&C was changing a FC (Field Contact) - 250 power supply or annunciator housing #1, in the annunciator logic cabinet. At approximately 8:20 p.m., annunciator panels H (Reactor Coolant System),

A. VISITING INSPECTORS INPUT TO RESIDENT INSPECTION REPORT


Plant Inspected: St Lucie Units 1 and 2

Report Nos.: 50-335/96-09 and 50-389/96-09

Plant Support: Occupational Radiation Exposure (83750)

Inspector: 
F. N. Wright

Branch Chief Concurrence:


for K. P. Barr

B.

IV. Plant Support

R1 Radiological Protection and Chemistry (RP&C) Controls

R1.3 Occupational Radiation Internal and External Exposure Control (83750)

a. Inspection Scope

The inspectors reviewed the personnel exposure records to verify radiation exposures were within regulatory limits and the licensee was implementing proper internal and external exposure control measures.

b. Observations and Findings

The inspectors found all internal and external personnel exposures were below regulatory limits. Tours of the Radiation Control Areas (RCAs) were made to verify that radiological areas were properly posted and controlled. Locked high radiation areas were found properly secured. The inspectors reviewed select licensee radiation surveys and made independent radiation surveys in those areas to verify radiological conditions were properly identified and posted.

The inspectors observed good use of engineering controls and work processes to control airborne radioactive contamination.

c. Conclusions

In general, the licensee appeared to be implementing effective radiological controls to minimize personnel exposures to internal and external radiation sources. No concerns with the licensee's internal or external exposure control programs were identified.

R1.5 Control of Radioactive Materials and Contamination (83750)

a. Inspection Scope

The inspectors reviewed licensee procedures for control of contaminated tools, discussed controls with tool room staff and radiation protection personnel, reviewed licensee radiation surveys of tool rooms, and made independent radiation surveys in tool rooms.

HP-2, "Florida Power and Light (FPL) Health Physics Manual," Rev. 10, Dated August 24, 1995, described the radiation protection program at FPL's nuclear power plants. The FPL contamination guidelines were summarized in Table 4.2, "Contamination Guidelines."

The licensee's contamination limits for materials, tools, equipment and solid waste unconditionally released from the RCA were:

1,000 dpm/100 cm² for loose beta and gamma contamination and

5,000 dpm/100 cm² for fixed beta and gamma contamination (direct measurement)

The licensee's contamination limits for tools and equipment used in the RCA were:

1,000 dpm/100 cm² for loose beta and gamma contamination and

10 mrem/hr for fixed beta and gamma contamination

b. Observations and Findings

The inspectors noted that the licensee had made some positive changes in tool controls since the previous inspection. The inspectors observed the hot tool room located in the Unit 1 Reactor Auxiliary Building (RAB) was manned during the inspection and secured when unattended. Additionally, the licensee had combined two clean tool rooms located outside the RCA and the licensee was improving tool tracking and inventory capabilities. The licensee was also able to obtain enough temporary tool room personnel to staff tool rooms at all times during the peak outage period.

The licensee planned to reduce the total number of issued tools. A backlog of contaminated tools from previous outages had accumulated in storage locations within the RCA. Staff reductions in decontamination personnel had resulted in decreased tool decontamination efforts and increased levels of contaminated tools in storage.

As permitted by licensee procedures, some tools were designated for use within the RCA and were referred to as hot tools. The hot tools had specific contamination limits which were greater than unconditional release limits. These tools were identifiable with purple paint. The inspectors toured shops and warehouses and examined vehicles and "gang boxes" outside the RCA for hot tools. No hot tools were found outside the RCA. The inspectors also made radiation and contamination surveys in clean and hot tool rooms. No tools exceeding limits for clean or hot tools were identified by the inspectors.

In discussions with tool room personnel, the inspectors found many were unaware of the specific radiation and contamination limits for clean or hot tools. The temporary tool room personnel were generally less knowledgeable of the tool contamination limits. However, tool room personnel were not responsible for determining contamination levels of tools.

The inspectors reviewed routine and special surveys of licensee tool rooms. The licensee spent approximately 162 hours surveying tools during the period of June 13-16, 1996. The announced radiation protection inspection began June 17, 1996. The licensee also spent another 116 hours surveying tool rooms during the first three days of the inspection (June 17-19, 1996). The licensee's survey efforts in

tool rooms during this seven day period were significant and not typical of routine monitoring.

During the licensee's surveys numerous tools were found outside the RCA having contamination levels in excess of the limits for use in clean areas. The licensee also identified numerous tools for use in the RCA having contamination limits in excess of the limits for hot tools.

The licensee's tool room surveys during the period of June 13-19, 1996, identified the following examples where contaminated tools were found outside the RCA:

On June 18, 1996, HPTs removed 12 M&TE tools from the licensee's clean tool room having contamination levels up to approximately 12,500 dpm/100 cm² (250 net counts per minute/probe).

On June 19, 1996, HPTs removed five rigging slings from the licensee's clean tool room having contamination levels from approximately 40,000 to 600,000 dpm/100 cm² (8,000 to 120,000 dpm/probe).

The licensee's tool room surveys during the period of June 13-19, 1996, identified the following examples where tools were found within the RCA having contamination levels in excess of the licensee's contamination limits for hot tools:

On June 13, 1996, HPTs removed nine tools from a temporary hot tool room having loose contamination levels from approximately 1,000 to 20,000 dpm/100 cm².

On June 14, 1996, HPTs removed five wrenches, from the Unit 1 hot tool room having loose contamination in the range of 1,000 to 4,000 dpm/100 cm².

On June 16, 1996, HPTs removed numerous tools from a temporary hot tool room having loose contamination levels from approximately 1,000 to 30,000 dpm/100 cm².

On June 16, 1996, HPTs removed numerous tools (licensee identified as two bags), from the Unit 1 hot tool room having loose contamination in the range of 1,000 to 120,000 dpm/100 cm².

In the February 1996, radiation protection program inspection the inspectors found a few contaminated tools in the hot tool room that were slightly above the licensee's limits. In response to the inspector's findings, the licensee secured the hot tool room when unattended for better control. A Non-Cited Violation (NCV) concerning the control of contaminated tools was identified at that time. The licensee identified all of the recent examples of tools having contamination levels in excess of the licensee's contaminated limits. However, these were additional examples of tools having contamination in excess of contamination limits previously identified by the inspectors in the February 1996, radiation protection inspection. Corrective measures

implemented by the licensee following the NCV were inadequate to prevent the additional violations identified in the recent and extensive tool room surveys. The failure to control contaminated tools in accordance with licensee procedures is identified as a violation (VIO 50-335/96-09-01, "Failure to Control Contaminated Tools In Accordance with Licensee Procedures"). The licensee opened a condition report for the purpose of identifying the cause of the contaminated tool violations and to cause appropriate corrective actions.

During tours of the licensee's facilities the inspectors found housekeeping was generally good. However, numerous drums containing low level contamination were still stored in the yard area within the RCA that were exposed to environmental conditions and could present problems during severe winds.

c. Conclusions

While the licensee was making progress in achieving controls for tools in general, the licensee's controls had not been effective in preventing contaminated tools from leaving the RCA or ensuring tools for use inside the RCA had contamination levels below the licensee's contamination limits.

R1.6 Maintaining Occupational Exposure ALARA (83750)

a. Inspection Scope

The inspectors reviewed the status of the licensee's collective dose for 1996 and the implementation of the person-rem budget program.

b. Observations and Findings

The inspectors attended an ALARA Review Board meeting held during the inspection. During the meeting, the inspectors noted the new ALARA dose budget program appeared to have strong management support and to have directly involved site department managers in the dose reduction process. Department managers were accountable for collective doses and required to take corrective actions to minimize collective dose for their departments. Managers were encouraged to utilize the corrective action program to capture successful activities into procedures and to document unsuccessful activities for appropriate corrective actions.

The collective doses for specific work activities were reviewed with ALARA personnel and the inspector inquired about specific tasks exceeding expected collective dose. The effects of recent staff reductions on site collective dose were also discussed with licensee personnel. Recent staff reductions had resulted in additional temporary and less experience personnel performing certain activities including shielding, insulation removal and decontamination during outages. It appeared that the use of temporary and less experienced personnel could reduce efficiency and therefore increase collective doses. The licensee had not quantified collective dose differences of experienced versus less experienced laborers for task and the inspector was unable to measure the impact that temporary personnel were having on collective

dose. However, no significant collective dose problems were identified during the inspector's reviews.

The licensee's 1996 annual collective dose goal of 326 person-rem was based on routine Re-Fueling Outage (RFO) activities and was one of the most challenging for the site. However, the work scope expansion for the Unit 1 Steam Generators (SGs) was significant enough to threaten achievement of the 1996 goal. The licensee had approximately 297 person-rem through June 19, 1996.

c. Conclusions

Management support for the ALARA program was good with increased management involvement in dose reduction activities. The dose budget program has increased site participation in reducing collective dose. Upper managements encouragement to document ALARA successes and failures in the corrective action program indicate understanding and willingness to implement quality control processes in ALARA activities. The unexpected SG work had significantly impacted the licensee's ability to achieve the challenging 1996 collective dose goals.

85 Staff Training and Qualification in Radiation Protection and Chemistry (83750)

a. Inspection Scope

The inspectors reviewed the qualifications of certain site and vendor HPTs on site for the Unit 1 RFO. Licensee Technical Specifications 6.3.1 required that staff exceed the minimum qualification requirements specified in ANSI/ANS-3.1-1978, "American National Standard for Selection and Training of Nuclear Power Plant Personnel."

b. Observations and Findings

The inspectors requested a review of vendor HPT resumes for technicians working in the on-going Unit 1 RFO. The inspectors also reviewed the qualifications of all site HPTs having less than five years of experience in FPL radiation protection programs.

The inspectors were able to review experience records for a portion of vendor HPTs hired for the on-going RFO. Vendor HPT resumes were reviewed by the licensee to determine experience levels for meeting ANSI qualification requirements.

c. Conclusions

The inspectors determined that the licensee had not lowered qualification requirements for site and vendor HPTs. All site and vendor HPTs qualification records reviewed by the inspectors documented compliance with the applicable qualification requirements. No violations or deviations were identified.

C. Exit Meeting Summary

The inspectors presented the inspection results to members of the licensee management at the conclusion of the inspection on June 21, 1996. 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.

D. PARTIAL LIST OF PERSONS CONTACTED

Licensee

Buchanan, H., Health Physics Supervisor
*McCullers, R., Health Physics Operations Supervisor

NRC

*Miller, M., Senior Resident Inspector
*Attended June 21, 1996 Exit Meeting

E. INSPECTION PROCEDURES USED

IP 83750: Occupational Radiation Exposure

F. ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-335, 389/96-09-01 VIO: Failure to Control Contaminated Tools In Accordance With Licensee Procedures.

Closed

NA

Discussed

NA

G. Conclusion/Assessment

Plant Support

The radiation protection program was adequately managed and internal and external exposure control programs were effectively implemented with all radiation exposures within 10 CFR Part 20 limits. (Paragraph R1.3)

A Violation, 50-335, 389/96-09-01, was identified concerning failure to follow procedures for the control of contaminated tools. (Paragraph R1.5)

Tours of licensee facilities showed generally good radiological housekeeping and controls. (Paragraph R1.5)

Increased management involvement in ALARA efforts were observed during the inspection. (Paragraph R1.6)

1.

NOTICE OF VIOLATION

Florida Power and Light Company
St. Lucie 1

Docket Nos. 50-335, 50-389
License Nos. DPR-67, NPF-15

During an NRC inspection conducted on June 17 through June 21, 1996, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG 1600, the violation is listed below:

Technical Specification 6.8.1.a requires that written procedures be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Rev. 2, February, 1978. Appendix A, paragraph 1.d includes administrative procedures for procedural adherence. QI 5-PR/PSL-1, Rev 68, "Preparation, Revision Review/Approval of Procedures," Section 5.13.1, states that all procedures shall be strictly adhered to.

HP-2, Florida Power and Light (FPL) Health Physics Manual, Rev. 10, describes the radiation protection program at FPL's nuclear power plants. The licensee's contamination guidelines are summarized in Table 4.2, "Contamination Guidelines," of the manual. The following contamination limits are described in Table 4.2.

The licensee's contamination limits for materials, tools, equipment and solid waste unconditionally released from the Radiation Control Area (RCA) are:

- 1,000 dpm/100 cm² for loose beta and gamma contamination and
- 5,000 dpm/100 cm² for fixed beta and gamma contamination (direct measurement)

The licensee's contamination limits for tools and equipment used in the RCA are:

- 1,000 dpm/100 cm² for loose beta and gamma contamination and
- 10 mrem/hr for fixed beta and gamma contamination

Contrary to the above:

1. On June 18 and 19, 1996, licensee HPTs found contaminated tools outside the RCA having contamination levels greater than the unconditional release limits.

On June 18, 1996, HPTs removed 12 M&TE tools from the clean tool room having contamination levels up to approximately 12,500 dpm/100 cm² (250 net counts per minute/probe).

On June 19, 1996, HPTs removed five rigging slings from the licensee's clean tool room having contamination levels from approximately 40,000 to 600,000 dpm/100 cm² (8,000 to 120,000 dpm/probe).

2. On June 13, 14, and 16, 1996, HPTs found tools in the RCA having contamination levels greater than the limits for tools and equipment utilized in the RCA.

On June 13, 1996, HPTs removed nine tools from a temporary hot tool room having loose contamination levels from approximately 1,000 to 20,000 dpm/100 cm².

On June 14, 1996, HPTs removed five wrenches, from the Unit 1 hot tool room having loose contamination in the range of 1,000 to 4,000 dpm/100 cm².

On June 16, 1996, HPTs removed numerous tools from a temporary hot tool room having loose contamination in the range of 1,000 to 30,000 dpm/100 cm².

On June 16, 1996, HPTs removed numerous (two bags) of tools, from the Unit 1 hot tool room having loose contamination in the range of 1,000 to 120,000 dpm/100 cm².

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

Pursuant to the provisions of 10 CFR 2.201, Florida Power and Light is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region II, and a copy to the NRC Resident Inspector at the facility that is the subject of this Notice, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include for each violation: (1) the reason for the violation, or, if contested, the basis for disputing the violation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

Under the authority of Section 182 of the Act, 42 U.S.C. 2232, this response shall be submitted under oath or affirmation.

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. However, if you find it necessary to include such information,

you should clearly indicate the specific information that you desire not to be placed in the PDR, and provide the legal basis to support your request for withholding the information from the public.

Dated at
this day of 1996

LIST OF ACRONYMS USED

ALARA	As Low As Reasonably Achievable
ANS	American Nuclear Society
ANSI	American National Standard Institute
CFR	Code Federal Regulations
cm	Centimeters
cpm	Counts Per Minute
dpm	Disintegration Per Minute
FPL	The Florida Power and Light Company
FR	Federal Register
HP	Health Physics
HPT	Health Physics Technician
IP	Inspection Procedure
mrem	Milli Roentgen Equivalent Man
M&TE	Measuring and Test Equipment
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PSL	Plant St. Lucie
QI	Quality Instruction
RAB	Reactor Auxiliary Building
RCA	Radiation Control Area
RFO	Re-Fueling Outage
RP&C	Radiological Protection and Chemistry
SG	Steam Generator
TS	Technical Specification
VIO	Violation

J. Cover Letter Paragraph

The contamination control violation described in the enclosed Notice is similar to a violation described in the Inspection Report 50-335/96-04 and 50-389/96-04 sent to you by our letter dated April 29, 1996. Recurring violations are of particular concern because the NRC expects licensees to learn from their past failures and to take effective corrective actions. Although NRC does not normally consider monetary civil penalties for Severity Level IV violations, the Enforcement Policy states that such penalties may be imposed for Severity Level IV violations that are similar to previous violations for which the licensee did not take effective corrective action. In this case, we have decided not to hold an enforcement conference nor to propose a civil penalty because this is the first repeat associated with a violation of procedure compliance. In your response to the enclosed Notice, you should document the specific actions taken and any additional actions you plan to prevent recurrence. We will review your response, including your proposed corrective actions, and the results of future inspections to determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.