



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION II  
ATLANTA FEDERAL CENTER  
61 FORSYTH STREET, SW, SUITE 23T85  
ATLANTA, GEORGIA 30303

July 17, 1997

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

FROM: Kerry D. Landis, Chief  
Reactor Projects Branch 3  
Division of Reactor Projects *Kerry D Landis*

SUBJECT: RII-97-A-0116 - FOREIGN MATERIAL EXCLUSION MONITORING  
INSUFFICIENT

The Division of Reactor Projects performed a review and independent inspection of this anonymous concern. Our inspection regarding this matter has been completed and our inspection findings were documented in the enclosed NRC Inspection Report 50-335,389/97-05, paragraph 03.1.

Based on the information provided, concern 1 was substantiated and a violation of regulatory requirements was identified and cited in Enclosure 2. Concern 2 was unable to be substantiated. Concern 3 was determined not to be an allegation.

This concludes the staff's activities regarding this matter. These allegations are considered closed. If you have any questions regarding this matter, please contact me.

Enclosures:

1. Allegation Evaluation Report
2. NRC Inspection Report 50-335,389/97-05

ALLEGATION EVALUATION REPORT

ALLEGATION RII-97-A-0116

QUALIFIED AND TRAINED FME MONITOR NOT STATIONED AT UNIT 2 CONTAINMENT

ST. LUCIE NUCLEAR PLANT  
DOCKET NO. 50-335, 389

CONCLUSION 1: A "qualified and trained" Foreign Material Exclusion Monitor was not stationed at the entrance to the to the Unit 2 containment although it was considered a FME zone at that time.

DISCUSSION: The following findings were documented in NRC Inspection Report 50-335,389/97-05, paragraph 03.1, Foreign Material Exclusion (FME) Control of the Unit 2 Containment Building.

03.1 Foreign Material Exclusion (FME) Control of the Unit 2 Containment Building (7/97)

a. Inspection Scope

The inspector reviewed the FME controls associated with control of material being used inside the Unit 2 containment building during the refueling outage after the containment closeout was complete. This inspection consisted of a review of the FME log, discussions with FME monitors, and Quality Instruction QI 13-PR/PSL-2, Revision 29, "Housekeeping and Cleanliness Control Methods."

b. Observations and Findings

At the end of the Unit 2 refueling outage, the containment building was controlled as an FME area. On May 23, 1997, the inspector reviewed the FME log book associated with the containment building. Inside the book were instructions which stated that "With the exception of maintenance personnel working on the Reactor Drain Tank/Containment Sump Project all other personnel shall complete the FME log. Health Physics personnel (later changed to Security) shall man the FME log desk and ensure that the log is completed for personnel entering and exiting the RCB. Maintenance personnel working on the Reactor Drain Tank/Containment Sump Project are not required to comply with the FME log requirements since a FME walk down of the work area will be performed at the completion of the project." Also in the log book, were log sheets indicating the material that was taken into and out of containment.

On May 29, after the containment was closed out and the FME area released, the inspector reviewed these log sheets and noted several items that had not been logged as having been removed from the containment. These items included: paper, safety belt, paperwork, pen, tape, bolts, radio with ear muffs, rubber suit, flashing light, clearance tags, miscellaneous hand tools, pipe wrench, five flashlights, crescent wrench, one bottle of snoop, and a gauge. In addition,

Enclosure

nineteen individuals signing in on the log failed to sign out upon exiting.

The inspector discussed the instructions listed in the FME log with various licensee management stating that these instructions did not agree with the site procedure for control of FME. The licensee stated that it was not their intention to maintain the containment as an FME area as defined in the QI. Their philosophy was that after the sump work was complete the entire area would be inspected and any remaining items would then be removed. Therefore it was not necessary to log all items entering into this particular area. However, they did require that personnel not working on the sump job complete the FME log. The inspector noted that the entrance to the containment was identified as an FME area, that an FME log was established to control material entering and exiting the area, and that an FME monitor is established.

Procedure QI 13-PR/PSL-2, Section 5.5, stated, in part, that for Quality Group B systems and components, "if an FME Control Area is required, the control area and controls shall be established prior to opening the system or component. FME controls in accordance with this procedure shall be established, as needed, to maintain the cleanliness requirements. Appendix B provides guidance on the methods of controlling foreign material." Section 7.6, "Definitions," states that Quality Group B applies to the containment vessel. Appendix B of this QI states in part that "FME control areas, as defined by QI 13-PR/PSL-2, are used in those situations where it is not feasible/practical to install an FME control device to prevent loss of foreign material into a system/component. Tools/materials which are taken into FME control areas are logged for accountability." In addition, Section 5.15, "General Housekeeping," step 11.A, states that, "Material accountability shall be applied when misplaced tools equipment, and other materials could be detrimental to the plant item involved. When material accountability is applied, tools and other materials shall be logged into and out of the area."

The inspector reviewed the site procedures for guidance on when a FME monitor was required and what training was required prior to assuming that position. QI 13-PR/PSL-2 stated that FME monitors may be used at the discretion of the Plant Management, to control the area around the reactor cavity when the reactor vessel head was removed and in the fuel handling building when work was taking place around the spent fuel pool. With regard to training, Appendix A, step 1, states that the reactor cavity monitor should receive orientation as to the refueling process, the reactor coolant system and this QI. The QI made no mention concerning FME monitors for other areas or any associated training.

10 CFR 50, Appendix B, Criterion V requires that activities affecting quality shall be prescribed by documented procedures of a type appropriate to the circumstances and shall be accomplished in accordance with these procedure. Procedure QI 13-PR/PSL-2 is the procedure that implements this requirement with regard to foreign material control. Failure to adequately control the material entering and exiting the Unit

Enclosure

2 containment is a violation of this procedure and is identified as VIC 50-389/97-05-01, "Failure to Control Foreign Material Entering and Exiting the Unit 2 Containment."

c. Conclusions

The inspector concluded that the licensee's implementation of the FME program at the entrance to the Unit 2 containment as the unit approached post-outage startup was insufficient to satisfy procedural requirements. A violation for failing to follow the governing procedure was identified.

**CONCLUSION:** Based on the information provided this concern was substantiated, in that the implementation of the procedural requirements controlling FME to the Unit 2 containment were found to be insufficient. This concern is considered closed.

**CONCERN 2:** Supervision is performing work in the plant for which they are not qualified.

**DISCUSSION:** Routine direct observation of work activities over a long period of time by the resident inspectors has not been able to substantiate this concern. The lack of any specific example along with objective evidence to inspect precluded the resident inspectors from conducting a focused inspection.

**CONCLUSION:** This concern was unable to be substantiated and is considered closed.

**CONCERN 3:** Security personnel are monitoring individuals who are being drug tested (FFD: urine testing) instead of doctors.

**DISCUSSION:** Who monitors the FFD testing was determined to not be an NRC regulated activity.

**CONCLUSION:** This concern is not an allegation and is considered closed.

Total Days Open 56

### CLOSED CASE CHRONOLOGY

Recd/Entered 5/22/97 5/23/97 3:32:48

RII-1997-A-0116

Tuesday, November 25, 1997

Date Closed 7/17/97

| CONCERN NO. | ACTION NO. | PERSO'N ASSIGNED  | DATE ASSIGNED | DATE DUE | DATE COMPLETE | DAYS TO COMPLETE |
|-------------|------------|---|---------------|----------|---------------|------------------|
| 1           | 4          | DEMIRANDA<br><b>Other</b><br>PERFORM QA CHECK FOR CONCERN.  | 7/18/97       | 8/1/97   | 8/1/97        | 14               |
|             | 3          | LANDIS<br><b>Closure Letter</b><br>ISSUED AER WITH COVER LTR TO OAC. ALLEGER : NONYMOUS.                                      | 5/27/97       | 8/27/97  | 7/17/97       | 51               |
|             | 2          | LANDIS<br><b>Inspection</b><br>DRP RESIDENTS INSPECT WITHIN 3 MONTHS. REF IR 335, 389/97-05, PARAGRAPH 03.1.                  | 5/27/97       | 8/27/97  | 7/14/97       | 48               |
|             | 1          | IGNATONIS<br><b>Initial ARB Meeting</b><br>SCHEDULE ARB MTG.  | 5/22/97       | 6/22/97  | 5/27/97       | 5                |
| 2           | 2          | LANDIS<br><b>Inspection</b><br>DRP RESIDENTS CHECK ON THE QUALIFICATIONS OF INDIVIDUALS/SUPERVISORS PERFORMING WORK. IR:97-11 | 5/27/97       | 11/17/97 | 7/17/97       | 51               |
|             | 1          | IGNATONIS<br><b>Initial ARB Meeting</b><br>SCHEDULE ARB MEETING   | 5/22/97       | 6/22/97  | 5/27/97       | 5                |
| 3           | 2          | DEMIRANDA<br><b>Other</b><br>NOT AN ALLEGATION. EICS CLOSE. NO FURTHER ACTION REQUIRED  | 5/27/97       | 6/27/97  | 6/2/97        | 6                |
|             | 1          | IGNATONIS<br><b>Initial ARB Meeting</b><br>SCHEDULE ARB MTG.  | 5/22/97       | 6/22/97  | 5/27/97       | 5                |

AT 65

## INDEX OF CONCERNS

RII-1997-A-0116

RII-1997-A-0116

Tuesday, November 25, 1997

**CONCERN:**  1 **Operations** **Anonymous** **Power Reactor**  
**DESCRIPTION:** A "QUALIFIED AND TRAINED" FOREIGN MATERIAL EXCLUSION MONITOR WAS NOT STATIONED AT THE ENTRANCE TO THE U-2 CONTAINMENT ALTHOUGH THE CONTAINMENT WAS CONSIDERED TO BE AN FME ZONE AT THAT TIME.  
**SUBSTANTIATED**  Y  
**CLOSURE:** The following findings were documented in NRC Inspection Report 50-335,389/97-05, paragraph O3.1, Foreign Material Exclusion (FME) Control of the Unit 2 Containment Building.

O3.1 Foreign Material Exclusion (FME) Control of the Unit 2 Containment Building (71707)

The inspector reviewed the FME controls associated with control of material being used inside the Unit 2 containment building during the refueling outage after the containment closeout was complete. This inspection consisted of a review of the FME log, discussions with FME monitors, and Quality Instruction QI 13-PR/PSL-2, Revision 29, "Housekeeping and Cleanliness Control Methods."

At the end of the Unit 2 refueling outage, the containment building was controlled as an FME area. On May 23, 1997, the inspector reviewed the FME log book associated with the containment building. Inside the book were instructions which stated that "With the exception of maintenance personnel working on the Reactor Drain Tank/Containment Sump Project all other personnel shall complete the FME log. Health Physics personnel (later changed to security) shall man the FME log desk and ensure that the log is completed for personnel entering and exiting the RCB. Maintenance personnel working on the Reactor Drain Tank/Containment Sump Project are not required to comply with the FME log requirements since a FME walk down of the work area will be performed at the completion of the project." Also in the log book, were log sheets indicating the material that was taken into and out of containment.

On May 29, after the containment was closed out and the FME area released, the inspector reviewed these log sheets and noted several items that had not been logged as having been removed from the containment. These items included; paper, safety belt, paperwork, pen, tape, bolts, radio with ear muffs, rubber suit, flashing light, clearance tags, miscellaneous hand tools, pipe wrench, five flashlights, crescent wrench, one bottle of snoop, and a gauge. In addition, nineteen individuals signing in on the log failed to sign out upon exiting.

The inspector discussed the instructions listed in the FME log with various licensee management stating that these instructions did not agree with the site procedure for control of FME. The licensee stated that it was not their intention to maintain the containment as an FME area as defined in the QI. Their philosophy was that after the sump work was complete the entire area would be inspected and any remaining items would then be removed. Therefore it was not necessary to log all items entering into this particular area. However, they did require that personnel not working on the sump job complete the FME log. The inspector noted that the entrance to the containment was identified as an FME area, that an FME log was established to control material entering and exiting the area, and that an FME monitor was established.

Procedure QI 13-PR/PSL-2, Section 5.5, stated, in part, that for Quality Group B systems and components, "if an FME Control Area is required, the control area and controls shall be established prior to opening the system or component. FME controls in accordance with this procedure shall be established, as needed, to maintain the cleanliness requirements. Appendix B provides guidance on the methods of controlling foreign material." Section 7.6, "Definitions," states that Quality Group B applies to the containment vessel. Appendix B of this QI states in part that "FME control areas, as defined by QI 13-PR/PSL-2, are used in those situations where it is not feasible/practical to install an FME control device to prevent loss of foreign material into a system/component. Tools/materials which are taken into FME control areas are logged for accountability." In

addition, Section 5.15, "General Housekeeping," step 11 A, states that, "Material accountability shall be applied when misplaced tools, equipment, and other materials could be detrimental to the plant item involved. When material accountability is applied, tools and other materials shall be logged into and out of the area."

The inspector reviewed the site procedures for guidance on when a FME monitor was required and what training was required prior to assuming that position. QI 13-PR/PSL-2 stated that FME monitors may be used at the discretion of the Plant Management, to control the area around the reactor cavity when the reactor vessel head was removed and in the fuel handling building when work was taking place around the spent fuel pool. With regard to training, Appendix A, step 1, states that the reactor cavity monitor should receive orientation as to the refueling process, the reactor coolant system and this QI. The QI made no mention concerning FME monitors for other areas or any associated training.

10 CFR 50, Appendix B, Criterion V requires that activities affecting quality shall be prescribed by documented procedures of a type appropriate to the circumstances and shall be accomplished in accordance with these procedure. Procedure QI 13-PR/PSL-2 is the procedure that implements this requirement with regard to foreign material control. Failure to adequately control the material entering and exiting the Unit 2 containment is a violation of this procedure and is identified as VIO 50-389/97-05-01, "Failure to Control Foreign Material Entering and Exiting the Unit 2 Containment."

The inspector concluded that the licensee's implementation of the FME program at the entrance to the Unit 2 containment as the unit approached post-outage startup was insufficient to satisfy procedural requirements. A violation for failing to follow the governing procedure was identified.

**CONCLUSION:**

Based on the information provided this concern was substantiated, in that the implementation of the procedural requirements controlling FME to the Unit 2 containment were found to be insufficient. This concern is considered closed.

---

**CONCERN:**  2 Operations Anonymous Power Reactor  
**DESCRIPTION:** SUPERVISION IS PERFORMING WORK IN THE PLANT FOR WHICH THEY ARE NOT QUALIFIED.  
**SUBSTANTIATED**  N  
**CLOSURE:** Routine direct observation of work activities over a long period of time by the resident inspectors has not been able to substantiate this concern. The lack of any specific example along with objective evidence to inspect precluded the resident inspectors from conducting a focused inspection.  
**CONCLUSION:** This concern was unable to be substantiated and is considered closed.

---

**CONCERN:**  3 Fitness For Duty Anonymous Power Reactor  
**DESCRIPTION:** SECURITY PERSONNEL / MONITORING INDIVIDUALS WHO ARE BEING DRUG TESTED (FFD: URINE TESTING) INSTEAD OF DOCTORS.  
**SUBSTANTIATED**  N  
**CLOSURE:** NOT AN ALLEGATION. EICS CLOSE. NO FURTHER ACTION REQUIRED

---

# ALLEGATION REPORT

CASE NO: RII-1997-A-0116

FACILITY: St. Lucie

CONCERN NO: (1)

DOCKET NO: 50-335, 389

ALLEGER: ANONYMOUS  
ADDRESS:  
HOME PHONE:

LOYER:  
E:  
DATE RECEIVED: 05/22/97



WHAT IS THE ALLEGATION?

1. A "qualified and trained" Foreign Material Exclusion monitor was not stationed at the entrance to the U-2 containment although the containment was considered to be in FME zone at that time.
2. Supervision is performing work in the plant for which they are not qualified.
3. Security personnel are monitoring individuals who are being drug tested (FFD: urine testing) instead of doctors.

WHAT IS THE REQUIREMENT/VIOLATION?

1. CI stated that a "qualified and trained" individual is not being used as the FME monitor for the Unit 2 containment.
2. CI stated that supervisors are not allowed to do actual work in the plant. Because they don't know how to do the work, the CI is afraid that eventually a supervisors poor work will result in someone getting hurt.
3. CI did not know if this was wrong or not but stated that it seemed like it was not right.

WHERE IS IT LOCATED?

1. Unit 2 containment
- 2 & 3. St. Lucie plant

WHEN DID IT OCCUR?

1. May 21 to present, 1997
2. Didn't give dates but simply stated "for the last couple of days or week."
3. Didn't say. He did not have first hand knowledge of this but was told about it.

WHO IS INVOLVED/WITNESSED? CI did not say.  
HOW/WHY DID IT OCCUR? Did not know.

WHAT EVIDENCE CAN BE EXAMINED?

1. FME log for Unit 2 Containment. FME procedure (Quality Instruction 13-PR/PSL-2, Housekeeping and Cleanliness Control Methods)
2. Work Orders
3. FFD plan

DID THE INDIVIDUAL EXPRESS A CONCERN TO THE LICENSEE?  
No. The CI stated that he did not want the licensee to know he had this concern.

WHAT IS THE STATUS OF THE LICENSEE'S ACTIONS? N/A

Allegor informed of NRC identity protection policy?... Y XX\_\_ N\_\_  
Did allegor request confidentiality?..... Y\_\_ N\_\_XX\_\_  
Did the allegor object to a licensee/state referral?... Y\_\_ N\_\_XX\_\_  
Was the allegor informed of DOL reporting requirements? Y\_\_XX\_\_ N\_\_

Type of Regulated Activity: (a) XX\_\_ Reactor b)\_\_ Vendor (c)\_\_ Materials  
(d)\_\_ Safeguards (e) other:\_\_\_\_\_

Ask all above questions, do not leave any blanks. Complete one sheet for each issue. Forward this form to: RII/SAC, P.O. BOX 845  
Atlanta, GA 30301. Do not retain any file copies subsequent to receipt by SAC.  
SAC phone numbers are (404) 331-4193 & 331-4194.

PREPARED BY: Joel T. Munday

DATE PREPARED: 05/23/97

**ALLEGATION REPORT**  
**CONTINUATION SHEET**

CASE NO: RII-1997-A-0116

FACILITY: St. Lucie

**ADDITIONAL INFORMATION**

I received a call from the CI stating that contract Health Physics personnel were being used as FME monitors. He stated that on May 21, the FME monitor at the entrance to the Unit 2 containment, was a contract HP not qualified for to be a monitor. He stated that on May 22 Security guards were asked to be the FME monitors, and that they too were not qualified.

He then stated that supervisors were performing work in the plant. The reason was that laborers had been laid off due to the outage ending but that management still required the work to be completed. Rather than take the "heat" from management when work didn't get completed, supervisors would do the work themselves. The CI stated that someone else told him that in one case a supervisor had rigged an eyebolt that was later found to have been rigged incorrectly. He had no further information about this incident. He was concerned that someone was going to get hurt due to this practice.

The CI then stated that he had been told that Security personnel were monitoring people who were being urine tested for FFD. He stated that a doctor used to monitor that process and having Security do this did not seem right.

The CI would not give his name because he said he was afraid that it would get back to his management who then might fire him or demote him.

---

---

---

---

---

**ACTION REQUIRED**

---

---

---

PREPARED BY: Joel T. Munday

DATE PREPARED: 5/23/97

May 18, 1995

# CASE CHRONOLOGY

## RII-94-A-0119

FACILITY: ST LUCIE

OPENED BY: O. DEMIRANDA

| DATE/INT'LS  | ACTIVITY   | SECTION |
|--------------|--|---------|
| 6/10/94;ODM  | DRP ALLEG REPORT: ANONYMOUS ALLEGER - 8<br>CONCERNS RELATED TO SECURITY  | 1       |
| 6/13/94;ODM  | FAX DTD 6/13/94 FROM ST. LUCIE LIST OF<br>ALLEGATIONS FROM NEWS ARTICLE MARKED RCVD FROM<br>BILL WHITE (SECURITY MANAGER) 6/8  | 1       |
| 6/16/94;ODM  | ARP MEETING.<br>AP: NMSS PERFORM INSPECTION (CONCERNS 1-8)   | 2       |
| 11/03/94;ODM | ARP MEETING MINUTES: REVIEW OF CONCERNS 2 AND 3<br><br>2. A LT HAS A DRINKING PROBLEM.<br><br>3. A SECURITY OFFICER FREQUENTLY SMELLS OF<br>ALCOHOL.<br><br>AP: DRP REFER TO LICENSEE, & NMSS REVIEW<br>LICENSEE RESPONSE<br><br>LICENSEE REFERRAL: YES - RESPONSE REQUIRED<br>OI/AP: NO<br>DOL/AP: NO<br>COMPLETION DATE: 60 DAYS | 2       |
| 11/21/94;ODM | NMSS CLOSURE MEMO FOR CONCERNS 1, 4-8.<br>ALLEGATIONS WERE PARTIALLY SUBSTANTIATED;<br>HOWEVER, NO VIOLATIONS OF REGULATORY<br>REQUIREMENTS WERE IDENTIFIED.   | 3       |
| 12/19/94;ODM | From: Oscar Demiranda (OXD)<br>To: DMV<br>Date: Monday, December 19, 1994 8:11 am<br>Subject: RII-94-A-0119 REFERRAL<br><br>DAVE - THIS ALLEGATION WAS RE-ARPED ON 11/3/94<br>FOR THE PURPOSE OF MAKING A LICENSEE REFERRAL.<br>ATTACHED IS THE ENCLOSURE FOR THE REFERRAL.  | NONE    |
| 12/27/94;ODM | LICENSEE REFERRAL LETTER   | 3       |

A/12/27/94





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

February 15, 1995

MEMORANDUM TO: B. Mallett, Deputy Director  
Division of Radiation Safety  
and Safeguards

FROM: O. DeMiranda, Senior Allegation Coordinator  
Enforcement and Investigation  
Coordination Staff

SUBJECT: RII-94-A-0119 - FLORIDA POWER AND LIGHT RESPONSE TO TURKEY  
POINT AND ST. LUCIE FITNESS FOR DUTY ALLEGATION

The enclosed licensee response is forwarded for your review in accordance with the action assigned from the Allegation Review Panel (ARP) meeting conducted on November 3, 1994 (attached). The ARP determined this allegation to be a fitness for duty issue and directed the Division of Reactor Projects to refer this matter to the licensee and the Division of Radiation Safety and Safeguards to perform a review of the licensee's response.

The allegation was referred to Florida Power and Light on December 27, 1994, and their response letter dated February 3, 1995, was received in the Region II office on February 15, 1995.

Your response should include an Allegation Summary, an inspection report, and any other documentation applicable to the case.

If you have any questions or need additional information or assistance please advise.

Enclosures: 1. FP&L Response letter dtd 2/3/95  
2. 11/3/94 ARP meeting minutes

cc: D. Verrelli, DRP

A/68

AMG/1140/37

# ARP MEETING 11/03/94

R11-94-A-0119      REPANEL      ST LUCIE      50-335,389

2. A LT has a drinking problem.
3. A security officer frequently smells of alcohol.

AP: DRP REFER TO LICENSEE, & NMSS REVIEW LICENSEE RESPONSE

LICENSEE REFERRAL: YES - RESPONSE REQUIRED

OI/AP: NO

DOL/AP: NO

COMPLETION DATE: 60 DAYS

| ARP ATTENDEES 11/03/94   |   |     |   |
|--|---|-----|---|
| ORA  | DRP   | DRS | DRSS  |
| <input checked="" type="checkbox"/> EVANS<br><input checked="" type="checkbox"/> DEMIRANDA<br><input checked="" type="checkbox"/> WOODRUFF | <input checked="" type="checkbox"/> BOGER<br><input checked="" type="checkbox"/> LANDIS |     | <input checked="" type="checkbox"/> JOHNSON<br><input checked="" type="checkbox"/> COLLINS<br><input checked="" type="checkbox"/> TESTA<br><input checked="" type="checkbox"/> GLOEPSON<br><input checked="" type="checkbox"/> TOBIN<br><input checked="" type="checkbox"/> BASSETT |
|  |   |     | <b>OI</b>   |
|  |   |     | <input checked="" type="checkbox"/> MCNULTY   |



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA STREET, N.W., SUITE 2900  
ATLANTA, GEORGIA 30333-0199

MAY 18 1995

NOTE TO: Bruno Uryc  
FROM: Anne Boland *[Signature]*  
SUBJECT: ALLEGATION RII-9-A-0119: MULTIPLE SECURITY CONCERNS AT ST. LUCIE  
POWER PLANT

Please find attached the subject file for your review. The eight allegations were anonymous (associated with a newspaper article); therefore, no final closure letter to the alleger is required. Six of the concerns were inspected by William Tobin and Lori Stratton, Division of Radiation Safety and Safeguards during the week of September 26-30, 1994 (Inspection Report 50-335, 389/94-21). Based on their evaluation, certain of the allegations, or portions thereof, were substantiated; however, licensee activities were conducted within the scope of the Physical Security Plan. No violations or deviations were identified.

In addition, two of the allegations were referred to the licensee for investigation. These concerns involved the fitness for duty associated with two members of the security force. The licensee partially substantiated the allegations; however, evidence of on-the-job drinking was not substantiated. Review of the licensee's investigation and associated corrective actions determined them to be satisfactory.

Based on the review of the two allegation summaries submitted by DRSS and the licensee's response to NRC's referral, I recommend this case for closure.

MAY 18 1995

Concur: *[Signature]*

69  
ATM





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

December 27, 1994

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

SUBJECT: ALLEGATION RII-94-A-0119

Gentlemen:

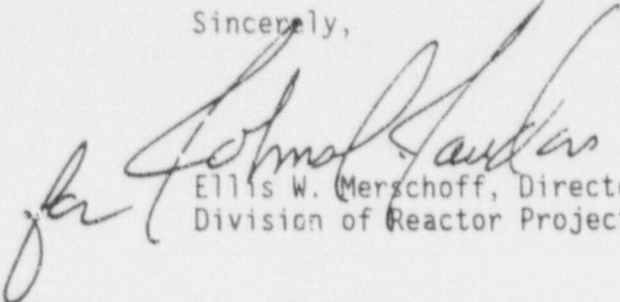
The enclosure to this letter documents information received by Region II from a concerned individual. The NRC has not made an attempt to ascertain the accuracy of the information. The enclosure is provided for your review so that you can take appropriate action.

The enclosed information is not being placed in the Public Document Room. Appropriate safeguards must be applied to the enclosed information in view of its unsubstantiated nature in order to avoid an unwarranted invasion of privacy or defamation of character of named or otherwise described individuals.

The enclosure contains information for your follow-up, and you are requested to initiate a review of this matter and provide us with your findings within 45 days of receipt of this letter. In order to ensure appropriate protection for the information, please mark the letter with your findings as containing "Information Exempt from Disclosure Under 10 CFR 2.790 (a)(6) and (7)." Indicate on the envelope that it is "TO BE OPENED BY ADDRESSEE ONLY."

If you have any questions regarding this matter, please feel free to contact Mr. Oscar DeMiranda, Enforcement and Investigation Coordination Staff, at (404) 331-4193.

Sincerely,

*for*   
Ellis W. Merschoff, Director  
Division of Reactor Projects

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

Enclosure: Summary of Referred Information

ENCLOSURE CONTAINS INFORMATION EXEMPT FROM  
DISCLOSURE UNDER 10 CFR 2.790(a)(6)(7)

A/70

950110254

cc w/o encl:

D. A. Sager  
Vice President  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0120

H. N. Paduano, Manager  
Licensing and Special Programs  
Florida Power and Light Company  
P. O. Box 14000  
Juno Beach, FL 33408-0420

C. L. Burton  
Plant General Manager  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0128

Robert E. Dawson  
Plant Licensing Manager  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0218

Harold F. Kreis, Esq.  
Newman & Holtzinger  
1615 L Street, NW  
Washington, D. C. 20036

John T. Butler, Esq.  
Steel, Hector and Davis  
4000 Southeast Financial Center  
Miami, FL 33131-2398

Bill Passeti  
Office of Radiation Control  
Department of Health and  
Rehabilitative Services  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

Jack Shrieve  
Public Counsel  
Office of the Public Counsel  
c/o The Florida Legislature  
111 West Madison Avenue, Room 812  
Tallahassee, FL 32399-1400

cc w/o encl: Continued see page 3

cc w/o encl: Continued  
Joe Myers, Director  
Division of Emergency Preparedness  
Department of Community Affairs  
2740 Centerview Drive  
Tallahassee, FL 32399-2100

Thomas R. L. Kindred  
County Administrator  
St. Lucie County  
2300 Virginia Avenue  
Ft. Pierce, FL 34982

Charles B. Brinkman  
Washington Nuclear Operations  
ABB Combustion Engineering, Inc.  
12300 Twinbrook Parkway, Suite 3300  
Rockville, MD 20852



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

NOVEMBER 21, 1994

MEMORANDUM FOR: Oscar Demiranda, Regional Allegation Coordinator

THRU: *DM*  
*11/14/94* Douglas M. Collins, Chief  
Nuclear Materials Safety and  
Safeguards Branch  
Division of Radiation Safety  
and Safeguards

FROM: *[Signature]*  
*11/19/94* David R. McGuire, Chief  
Safeguards Section  
Nuclear Materials Safety and  
Safeguards Branch  
Division of Radiation Safety  
and Safeguards

SUBJECT: ST. LUCIE SECURITY ISSUES, (CASE NUMBER: RII-94-A-0119)

The Safeguards Staff has inspected the eight issues identified in this Allegation. Attachment 1, Inspection Report No. 94-21, concludes there were no violations identified.

Attachment 2, Allegation Summary, addresses all eight concerns, but items 2 and 3 could not be closed. Item Nos. 2 and 3 are to be referred to the licensee for action. There is no "allegor" to correspond with. The security officer, quoted in the newspaper article, has denied making the allegations, and, has no knowledge of any security nor safety issues at St. Lucie.

It is recommended that Items 1, 4-8, be closed.

Attachments: 1. Inspection Report No. 94-21 (non-Safeguards Information portions)  
2. Allegation Summary

*A-122*

*amof 140131*

10/25/94

# SAFEGUARDS INFORMATION

OCTOBER 25, 1994

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. 50-335/94-21 AND 50-389/94-21

Gentlemen:

This refers to the inspection conducted by W. Tobin of this office on September 26 - 30, 1994. 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 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  
JOHN POTTER FOR:

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

Enclosure:  
NRC Inspection Report  
(Safeguards Information)

cc w/encl: (See page 2)

ATTACHMENT 1

# SAFEGUARDS INFORMATION

Document transmitted herewith  
contains sensitive unclassified  
information. When separated from  
enclosures, this document is decontrolled

Florida Power and Light Company

SAFEGUARDS INFORMATION  
2

cc w/encl:  
D. A. Sager  
Vice President  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0128

H. N. Paduano, Manager  
Licensing and Special Programs  
Florida Power and Light Company  
P. O. Box 14000  
Juno Beach, FL 33408-0420

C. L. Burton  
Plant General Manager  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0128

cc w/Inspection Summary:  
Robert E. Dawson  
Plant Licensing Manager  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0218

Harold F. Reis, Esq.  
Newman & Holtzinger  
1615 L Street, NW  
Washington, D. C. 20036

John T. Butler, Esq.  
Steel, Hector and Davis  
4000 Southeast Financial Center  
Miami, FL 33131-2398

Bili Passeti  
Office of Radiation Control  
Department of Health and  
Rehabilitative Services  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

Jack Shreve  
Public Counsel  
Office of the Public Counsel  
c/o The Florida legislature  
111 West Madison Avenue, Room 812  
Tallahassee, FL 32399-1400

cc w/Inspection Summary: cont'd on page 3

SAFEGUARDS INFORMATION

Document transmitted herewith  
contains sensitive unclassified  
information. When separated from  
enclosures, this document is decontrolled

# SAFEGUARDS INFORMATION

Florida Power and Light Company 3

cc w/Inspection Summary: cont'd  
 Joe Myers, Director  
 Division of Emergency Preparedness  
 Department of Community Affairs  
 2740 Centerview Drive  
 Tallahassee, FL 32399-2100

Thomas R. L. Kindred  
 County Administrator  
 St. Lucie County  
 2300 Virginia Avenue  
 Ft. Pierce, FL 34982

Charles B. Brinkman  
 Washington Nuclear Operations  
 ABB Combustion Engineering, Inc.  
 12300 Twinbrook Parkway, Suite 3300  
 Rockville, MD 20852

Distribution w/Inspection Summary:  
 K. Landis, RII  
 J. Norris, NRR  
 PUBLIC

NRC Resident Inspector  
 U.S. Nuclear Regulatory Comm.  
 7585 South Highway A1A  
 Jensen Beach, FL 34957-2010

Distribution w/encl:  
 NRR/DRIS/SB

| SEND | ORC  | RII:DRSS               | RII:DRSS                     | RII:DRSS                   | RII:DRP  |       |
|------|------|------------------------|------------------------------|----------------------------|----------|-------|
| TO   | NAME | WTobin <i>W. Tobin</i> | LStratton <i>L. Stratton</i> | DMcGuire <i>D. McGuire</i> | KLandis  |       |
| PDR? | DATE | 10/13/94               | 10/13/94                     | 10/13/94                   | 10/13/94 | / /94 |
| Yes  | No   | COPY?                  | Yes                          | No                         | Yes      | No    |

OFFICIAL RECORD COPY

DOCUMENT NAME: G:\RPTS\SS\STL9421.RSS

## SAFEGUARDS INFORMATION

Document transmitted herewith  
 contains sensitive unclassified  
 information. When separated from  
 enclosures, this document is decontrolled



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

Report Nos.: 50-335/94-21 and 50-389/94-21

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: September 26 - 30, 1994

Inspector: William M. Masnyk for  
W. Tobin, Senior Safeguards Inspector

10-25-94  
Date Signed

Accompanying Personnel: L. Stratton, Safeguards Inspector

Approved by: William J. Tobin for  
D. R. McGuire, Chief  
Safeguards Section  
Nuclear Materials Safety and Safeguards Branch  
Division of Radiation Safety and Safeguards

10/24/94  
Date Signed

### SUMMARY

#### Scope:

This routine, unannounced inspection was conducted in the areas of the Safeguards Program for Nuclear Power Reactors, specifically, the Security Organization, Quality Control Audits, Access Controls, Records and Reports, and Licensee Event Report (LER) No. S94-001.

#### Results:

In the areas inspected, violations or deviations were not identified. With respect to the inspected areas, the licensee continues to have an effective and well managed Safeguards Program. The security force is adequately staffed, audits appear thorough, access controls are dependable, and records and reports are timely and accurate. LER No. S94-001 was closed.

SAFEGUARDS INFORMATION

Document transmitted herewith  
contains sensitive unclassified  
information. When separated from  
enclosures this document is decontrolled





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

July 26, 1996

EA 96-236 & EA 96-249

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

SUBJECT: NRC SPECIAL INSPECTION REPORT 50-335/96-12, 50-389/96-12

Dear Mr. Plunkett:

On July 12, 1996, the NRC completed a special inspection of engineering activities at your St. Lucie 1 and 2 facilities. The enclosed report presents the results of that inspection. Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, plant drawings, and engineering evaluations.

Based on the results of this inspection, five apparent violations were identified and are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600.

One of the apparent violations is of concern because it indicates that deficiencies have existed in your configuration management processes which have manifested themselves in failures to ensure that the design of the plant was properly incorporated into plant procedures and, to a lesser degree, drawings. While no plant event has been tied to the inaccuracies thus far identified, we are concerned about the potential impact of inaccuracies which may not yet have been discovered.

In addition to configuration management issues, four apparent violations were identified in the area of preparation of safety evaluations under 10 CFR 50.59. These apparent violations are of concern because they indicate that weaknesses exist in both recognizing the need for safety evaluations and in the process applied in assessing the impact of changes upon the plant.

A predecisional enforcement conference to discuss these apparent violations has been scheduled for August 19, 1996. The decision to hold a predecisional enforcement conference does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. This conference is being held to obtain information to enable the NRC to make an enforcement decision, such as a common understanding of the facts, root causes, missed opportunities to identify the apparent violations sooner, corrective actions, significance of the issues and the need for lasting and effective corrective actions. In addition, this is an opportunity for you to point out any errors in our inspection report and for you to provide any

ALS

4608120108

information concerning your perspectives on 1) the severity of the violations, 2) the application of the factors that the NRC considers when it determines the amount of a civil penalty that may be assessed in accordance with Section VI.B.2 of the Enforcement Policy, and 3) any other application of the Enforcement Policy to this case, including the exercise of discretion in accordance with Section VII.

You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding these apparent violations required at this time.

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

Sincerely,

Original Signed By Jon R. Johnson

Jon R. Johnson, Acting Director  
Division of Reactor Projects

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

Enclosure: Inspection Report 50-335/96-12, 50-389/96-12

cc w/encl:  
J. A. Stall  
Site Vice President  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0128

H. N. Paduano, Manager  
Licensing and Special Programs  
Florida Power and Light Company  
P. O. Box 14000  
Juno Beach, FL 33408-0420

J. Scarola  
Plant General Manager  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0128

cc w/encl cont'd: (See page 3)

cc w/encl: Continued  
E. J. Weinkam  
Plant Licensing Manager  
St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0218

J. R. Newman, Esq.  
Morgan, Lewis & Bockius  
1800 M Street, NW  
Washington, D. C. 20036

John T. Butler, Esq.  
Steel, Hector and Davis  
4000 Southeast Financial Center  
Miami, FL 33131-2398

Bill Passetti  
Office of Radiation Control  
Department of Health and  
Rehabilitative Services  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

Jack Shreve, Public Counsel  
Office of the Public Counsel  
c/o The Florida Legislature  
111 West Madison Avenue, Room 812  
Tallahassee, FL 32399-1400

Joe Myers, Director  
Division of Emergency Preparedness  
Department of Community Affairs  
2740 Centerview Drive  
Tallahassee, FL 32399-2100

Thomas R. L. Kindred  
County Administrator  
St. Lucie County  
2300 Virginia Avenue  
Ft. Pierce, FL 34982

Charles B. Brinkman  
Washington Nuclear Operations  
ABB Combustion Engineering, Inc.  
12300 Twinbrook Parkway, Suite 3300  
Rockville, MD 20852

cc w/encl: Continued  
E. J. Weinkam  
Plant Licensing Manager  
2St. Lucie Nuclear Plant  
P. O. Box 128  
Ft. Pierce, FL 34954-0218

J. R. Newman, Esq.  
Morgan, Lewis & Bockius  
1800 M Street, NW  
Washington, D. C. 20036

John T. Butler, Esq.  
Steel, Hector and Davis  
4000 Southeast Financial Center  
Miami, FL 33131-2398

Bill Passeti  
Office of Radiation Control  
Department of Health and  
Rehabilitative Services  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

Jack Shreve, Public Counsel  
Office of the Public Counsel  
c/o The Florida Legislature  
111 West Madison Avenue, Room 812  
Tallahassee, FL 32399-1400

Joe Myers, Director  
Division of Emergency Preparedness  
Department of Community Affairs  
2740 Centerview Drive  
Tallahassee, FL 32399-2100

Thomas R. L. Kindred  
County Administrator  
St. Lucie County  
2300 Virginia Avenue  
Ft. Pierce, FL 34982

Charles B. Brinkman  
Washington Nuclear Operations  
ABB Combustion Engineering, Inc.  
12300 Twinbrook Parkway, Suite 3300  
Rockville, MD 20852

Distribution w/encl: (See page 4)

Distribution w/encl:

J. Lieberman, OE  
 B. Summers, OE:EA file (2 LTRHD)  
 K. D. Landis, RII  
 J. A. Norris, NRR  
 B. R. Crowley, RII  
 G. A. Hallstrom, RII  
 W. H. Rankin, RII  
 S. H. DuBose, RII  
 PUBLIC

NRC Resident Inspector  
 U.S. Nuclear Regulatory Comm.  
 7585 South Highway A1A  
 Jensen Beach, FL 34957-2010

| OFFICE    | RII:DRP   | RII:DRP   | RII:DRS   | RII:DRS   | RII:DRP   | RII:EICS  |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| SIGNATURE |           |           |           |           |           |           |
| NAME      | ELea:dka  | MMiller   | WMiller   | JYork     | JJohnson  | BUryc     |
| DATE      | 08 / / 96 | 08 / / 96 | 08 / / 96 | 08 / / 96 | 08 / / 96 | 08 / / 96 |
| COPY?     | YES NO    | YES NO    | YES NO    | YES NO    | YES NO    | YES NO    |

OFFICIAL RECORD COPY

DOCUMENT NAME: A:\SL9612.ENG

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

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

Report No: 50-335/96-12, 50-389/96-12

Licensee: Florida Power & Light Co.

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

Location: 9250 West Flagler Street  
Miami, FL 33102

Date: July 12, 1996

Inspectors: M. Miller, Senior Resident Inspector  
W. Miller, Resident Inspector (acting)  
J. York, Reactor Inspector

Approved by: K. Landis  
Chief, Reactor Projects Branch 3  
Division of Reactor Projects

07/20/96

## EXECUTIVE SUMMARY

St. Lucie Nuclear Plant, Units 1 & 2  
NRC Inspection Report 50-335/96-12, 50-389/96-12

This special inspection included aspects of licensee's configuration management and 10 CFR 50.59 programs. Specifically, the inspection examined the extent to which plant changes were appropriately incorporated into procedures and drawings and the performance of 10 CFR 50.59 safety evaluations. Conclusions included the following:

- A review of a number of screenings and evaluations performed pursuant to 10 CFR 50.59 resulted in the identification of four apparent violations:
  - One example of an apparent failure to perform a safety evaluation due to a failure to employ engineering controls in the construction of the Unit 2 Control Element Drive Mechanism Control System room and a continuing failure to recognize the nondocumented nature of the room (paragraph E1.1.b.1).
  - One example of an apparent failure to identify that the installation of a temporary fire pump represented a change to the plant as described in the Update Final Safety Analysis Report, resulting in a failure to perform a safety evaluation (paragraph E1.1.b.2).
  - One example of an apparent failure to recognize that refueling equipment setpoints were included in the Updated Final Safety Analysis Report while performing a safety evaluation screening, leading to a failure to perform a safety evaluation (paragraph E1.1.b.3).
  - One example of an apparent failure to recognize an unreviewed safety question in the development of a safety evaluation for an Emergency Diesel Generator fuel oil transfer line valve lineup change (paragraph E1.1.b.4).
- A review of off-normal operating procedures relating to safety-related annunciators identified a number of inaccuracies (paragraph E7.1).
- Five apparent failures to properly incorporate Plant Change/Modification packages into drawings and procedures were identified (paragraph E7.2).

## Report Details

### E1 Conduct of Engineering

#### E1.1 Safety Evaluations/10 CFR 50.59 Issues (37550, 71707)

##### a. Inspection Scope

The inspectors reviewed a sample of the licensee's safety evaluations (SEs) performed pursuant to 10 CFR 50.59. The evaluations were reviewed for threshold for determining if an unreviewed safety question (USQ) existed because of an increase in the probability of a design basis accident occurring, an increase in equipment malfunction, a reduction in the margin of safety, or an increase in radiation dose consequences. These evaluations were also reviewed for adequacy of screening and assumptions used for the safety evaluations.

##### b. Observations and Findings

The inspectors reviewed twelve SEs or issues which might require SEs. The issues were:

- Cracking of Westinghouse Alloy 600 Mechanical Steam Generator Plugs.
- Temporary Relocation of Class Break on Intake Cooling Water.
- Installation of Temporary Fire Penetration Seals in Pipe Barrier BW064.
- Temporary Installation of Strain Measuring Devices on the Pressurizer Relief Valve Discharge Piping.
- Safety Injection Tank (SIT) Discharge/Loop Check Valve Stroke Test-Unit 1.
- Freeze Seal Application for V3651 and V3652 on the 1B Shutdown Cooling Return Line.
- Safety Evaluation For Boraflex Blackness Testing Results.
- Wide Range Nuclear Instrumentation Temporary System Alteration.
- Temporary Configuration for Control Element Drive Mechanism Control System (CEDMCS) Cooling System and Enclosure, Unit 2.
- Safety Evaluation for Inoperable Fire Pump
- St. Lucie Unit 1 Refueling Equipment Underload and Overload Settings.



- The Isolation of Fuel Oil Supply Line to the 2B Emergency Diesel Generator.

Problems were identified with the last four items and the details are discussed in the following paragraphs.

1) Temporary Configuration for CEDMCS Cooling System and Enclosure

On June 4, 1996, a control room annunciator indicated that an undervoltage condition existed on the CEDMCS. Operations responded to the CEDMCS equipment and noted that the CEDMCS enclosure was approximately 11 degrees warmer than normal. This enclosure is located in the cable spreading room on the 43 foot elevation of the reactor auxiliary building.

Following this event, an In-House Event Report and Condition Reports (CRs) 96-1238, 96-1245 and 96-1325 were issued. The following items with appropriate plant corrective action tracking numbers were identified by these reports:

- CEDMCS enclosure and air conditioning units did not appear on the plant's controlled drawings. (STAR 951320)
- CEDMCS enclosure air conditioning units were not seismic qualified. Final design was in process to provide seismic restraints for the air condition units. (PM 96-06-203)

As part of the action for CR 96-1325, a 10 CFR 50.59 safety evaluation was performed on the CEDMCS enclosure. The evaluation found that this air conditioned enclosure was erected in the early 1980's during the pre-operational testing phase. Testing performed at that time found that the CEDMCS enclosure required an air conditioned environment to prevent overheating of the four CEDMCS cabinets. The licensee's current review determined that the design of the enclosure was acceptable, except that the air conditioning units and one air conditioning duct presented a hazard to safety related equipment in a seismic event. Therefore, seismic supports and restraints were provided for the air conditioning units and duct prior to the unit's restart on June 13.

The inspector reviewed the 10 CFR 50.59 SE prepared for the design and installation of the seismic restraints and justification of the installation of the CEDMCS enclosure. A 10 CFR 50.59 review was apparently not performed when the enclosure was originally erected. The CEDMCS was described in the Updated Final Safety Evaluation Report (UFSAR) but the cooling system and enclosure for the CEDMCS were not described in the UFSAR. This was identified as another example of Unresolved Item (URI) 50-335,389/96-04-09, "Failure to Update UFSAR."

The failure to perform an evaluation as required by 10 CFR 50.59 prior to, or at any time subsequent to, making a change to the plant as described by the UFSAR is an apparent violation (EEI 50-389/96-12-01, "Failure to Perform a 10 CFR 50.59 Safety Evaluation for CEDMCS Enclosure," EA 96-236).

2) Safety Evaluation for Inoperable Fire Pump

During the Spring 1996 Unit 1 refueling outage, one of the two Unit 1 Emergency Diesel Generators (EDGs) had been placed out of service to perform maintenance and modification work activities. Only one EDG was in service to provide power in the event of a loss of offsite power event. To prevent a possible overload on the single EDG unit, a number of breakers to various components were opened and the units 480V electrical busses were crosstied in accordance with OP 1-0910024, Rev 6, "Crosstying/Removal of 480V Buses." One of the components removed from service was Fire Pump 1B. The breaker to this fire pump was opened on May 21, and this pump was removed from service and remained out of service on June 8.

AP 1800022, Rev 16, "Fire Protection Plan," Appendix A, Sections 2.2 and 2.3 required two fire pumps rated at a capacity of 2300 gpm to be operable at all times. Appendix A, Section 4.1.A, stated that with one of the two fire pumps inoperable, the inoperable equipment was to be restored to service within seven days or an alternate backup pump was to be provided within the next 30 days.

Fire Pump 1B had been out of service for 18 days. The compensatory measure established for this pump being out of service was the installation of a portable gasoline engine drive pump rated at 750 gpm. This pump had been connected to take suction from the fire protection water storage tank for Fire Pump 1A. This alternate pump was not of the same capacity as one of the two required pumps and a justification was not provided to demonstrate that this pump was of adequate capacity to meet the maximum fire flow requirement for the safety related areas of the plant. The licensee initiated a CR to review this item.

The licensee informed the inspector that the out of service pump could be restored to operability by restoring the existing open breaker to the closed position. Also, the 30 day time to provide an alternate backup pump had not been exceeded. This met the requirements of AP 1800022 for one pump being inoperable.

Resolution of CR 96-1356 indicated that the installation of the portable fire pump as the compensatory measure with one of the permanently installed fire pumps out of service was performed without an engineering evaluation to ensure adequate capacity and without a review under 10 CFR 50.59. The inspector found that the installation of the temporary pump resulted in a change to the

plant as described in the UFSAR, Figure 9.2-5, "Flow Diagram Fire Water, Domestic & Makeup Systems." The inspector concluded that a safety evaluation should have been prepared to justify and document the temporary configuration. The licensee stated that no 10 CFR 50.59 screening (and hence, no evaluation) was performed for this installation because the temporary pump, and its associated piping, was installed via Work Order, with no pre-approved procedure and outside the licensee's Temporary System Alteration process (which, if exercised, would have required a safety screening/evaluation). This is an apparent violation (EEI 50-335,389/96-12-02, "Failure to Perform a 10 CFR 50.59 Safety Evaluation For Use of a Temporary Fire Pump," EA 96-236).

3) Refueling Equipment Overload and Underload Settings

CR 96-812 was issued on the SE SEFJ-96-020 by the licensee. The report stated that an engineering evaluation had been written to modify the overload and underload setpoints described in the UFSAR without performing a 50.59 safety analysis/evaluation. These overload and underload load cell setpoints provide a margin to account for resistance encountered while lifting or lowering fuel assemblies and prevent exceeding the fuel assembly and refueling equipment design loads.

The licensee had obtained information from the vendor for use in this Unit 1 refueling outage which would allow an increase in hoist interrupt from 10 percent of the weight of a fuel assembly to 18 percent (approximately 200 pounds). The original engineering analysis did not take into account that these changes in setpoint values would affect the UFSAR and thus the CR was written.

St. Lucie Quality Instruction (QI) 2.0, "Engineering Evaluations," Rev 1 dated January 31, 1996, provides general requirements and guidance for the development and processing of engineering evaluations. This procedure references QI 2.1, "10 CFR 50.59 Screening/Evaluation," Rev 1 dated March 30, 1996, which stated, in part, that the screening process was designed to determine whether an activity required a complete 10 CFR 50.59 by asking a series of four questions. One question, "Does the change represent a change to procedures as described in the SAR?" should have been answered "yes" in the case of the original engineering analysis. The procedure also stated that, "A positive response to any of the first four...questions requires a 10 CFR 50.59 evaluation."

The Facility Review Group (FRG), the site safety committee, noted that a safety evaluation was not present with the requested procedure change and returned the procedure to the engineering group for correction and the CR was written to identify the problem. This failure to perform an evaluation as required by 10 CFR 50.59 prior to making a change to plant procedures described

in the UFSAR is an apparent violation (EEI 50-335/9F-12-03, "Failure to Perform a 10 CFR 50.59 Safety Evaluation For Change in Setpoints Listed in UFSAR," EA 96-136).

4) Safety Evaluation for Closing Manual Valve to EDG Fuel Supply

In July, 1995, the inspector reviewed SE JPN-PSL-SENS-95-013 which was prepared to allow operation with a manual isolation valve closed in the 2B EDG fuel oil (FO) line from the Diesel Fuel Oil Storage Tank (DFOST) to the day tanks. The configuration was proposed when a leak was determined to exist in the underground line between the two tanks. The action was designed to minimize the amount of FO released to the environment until the leak could be identified and corrected.

As a compensatory measure, the licensee proposed dedicating a Non-Licensed Operator (NLO) to the task of opening the closed valve in the event of an EDG start. The licensee calculated that the EDG day tanks contained enough FO to allow 126 minutes of EDG operation at full load before a transfer of FO was required. The licensee then specified that the NLO would be required to open the valve within 20 minutes of an EDG start. Procedures were revised to include direction to open the valve on an EDG start, and administrative controls were put in place to ensure that the NLO would not be required to perform any other immediate response duties. Additionally, the licensee performed a response time test, placing the operator at the G-2 warehouse (as far away from the EDG as he could credibly be in the protected area) and requiring the NLO to proceed to the valve and open it. The NLO performed this task in approximately seven minutes.

In considering the issue, the licensee employed Probabilistic Risk Assessment (PRA) techniques to estimate the increase in the risk of the loss of the 2B3 bus due to a failure of either the operator to open the valve or a failure of the valve to be able to be opened. The licensee concluded that the increase in probability was approximately 6 percent. However, in considering 10 CFR 50.59 criteria, the licensee concluded that no increase in the probability of failure of a component important to safety was created by the proposed action. The inspector questioned the licensee on this issue. The licensee explained that a deterministic conclusion of no increased probability was reached when the existence of procedural guidance and heightened awareness was balanced against the approximate 6 percent increase in failure probability presented by the two new failure modes.

The inspector noted that 10 CFR 50.59 was written in terms of absolute increases in the probabilities of failure represented by a proposed change. The inspector continued to question whether 10 CFR 50.59 criteria could ever be satisfied when new failure modes are imposed on a previously reviewed system (i.e. whether added risk, once qualitatively established, could be completely

mitigated). The inspector concluded that insufficient guidance existed from a regulatory perspective to take immediate issue with the licensee's rationale. Further, the inspector concluded that the licensee had taken prudent measures to ensure the continued operability of the 2B EDG while minimizing the FO leak's effect on the environment. The inspector referred the question to the Office of Nuclear Reactor Regulation for resolution.

After consideration of the issue, the NRC determined that the actions taken by the licensee in this instance introduced two new failure modes to the EDG system; failure of the operator to unisolate the fuel oil line and failure of the manual isolation valve to cycle. As a result, the NRC has concluded that the licensee's actions necessarily increased the probability of a failure of a component important to safety and, as such, represented a USQ, as defined in 10 CFR 50.59. Consequently, this action is identified as an apparent violation (EEI 50-389/96-12-04, "Unreviewed Safety Question Involving EDG 2B," EA 96-236).

#### c. Conclusions on Conduct of Engineering

The inspectors concluded that four apparent violations relating to CFR 50.59 safety evaluations existed. The inspectors noted that these issues varied both in vintage and in individual detail. Summarizing, the examples were the result of:

- 1) One example of a failure to perform a safety evaluation due to a failure to employ engineering controls in the construction of the Unit 2 CED room and a continuing failure to recognize the undocumented nature of the room.
- 2) One example of a failure to identify that the installation of a temporary fire pump represented a change to the plant as described in the UFSAR, resulting in a failure to perform a safety evaluation.
- 3) One example of a failure to recognize that refueling equipment setpoints were included in the UFSAR while performing a safety evaluation screening, leading to a failure to perform a safety evaluation. This example was identified by the licensee and corrected before any actual change took place.
- 4) One example of a failure to recognize an unreviewed safety question in the development of a safety evaluation for an EDG fuel oil transfer line valve lineup change.

#### E7 Quality Assurance In Engineering Activities

##### a. Inspection Scope

During the week of May 20, the inspector performed a walkdown of the Unit 1 Plant Auxiliary Control Board (PACB) safety-related annunciators

LA and LB to verify the accuracy of annunciator response procedures. This consisted of a review of the following procedures and engineering drawings, including:

- ONOP 2-0030131, Rev 51, "Plant Annunciator Summary"
- Other Procedures
- Applicable Engineering Drawings
- UFSAR Section 7.5

b. Observations and Findings

As a result of the walkdowns, the following discrepancies were noted:

| Procedure  | Attribute   | Erroneous Attribute  | Correct Attribute  |
|--|---|--|--|
| ONOP 2-0030131,<br>Rev 51,<br>"Plant Annunciator<br>Summary" | Annunciator LA-6<br>"ATMOS STM DUMP<br>ISOL VALVES MV-08-<br>15, MV-08-17 MOTOR<br>OVERLOAD VALVES<br>CLOSED" | Indicated Condition<br>"C"<br>"Feeder breaker open<br>to MV-08-15 or 16" | Indicated Condition<br>"C"<br>"Feeder breaker open<br>to MV-08-15 or 17"                           |
|  | Annunciator LA-9<br>"DIESEL OIL DAY<br>TANKS 2A1, 2A2<br>LOW-LOW LEVEL"                                       | Sensing Elements<br>listed as LS-59-006A<br>and 10A                      | LS-59-9A and 14A   |
|  | Annunciator LA-12<br>"ATM STM DUMP MV-<br>08-18A/18B<br>OVERLOAD/SS ISOL"                                     | Indicated conditions,<br>CWD reference and<br>sensing element            | This indicated<br>condition and<br>contacts were<br>removed by PC/M<br>275-290, closed<br>10/28/92 |
|  | Annunciator LB-9<br>"DIESEL OIL DAY<br>TANKS 2B1, 2B2<br>LOW-LOW LEVEL"                                       | Sensing Elements<br>listed as LS-59-018B<br>and 024B                     | LS-59-021B and 028B  |
|  | Annunciator LB-14<br>"FUEL POOL<br>HIGH/LOW LEVEL<br>HIGH TEMP"   | Sensing Element TA-<br>4421 not listed                                   |  |
|  | LB-10<br>"COMPONENT<br>COOLING WTR SURGE<br>TANK HIGH LEVEL<br>COMPARTMENT B<br>LOW LEVEL"                    | Sensing Element does<br>not specify contact<br>71X                       |  |
|  | Annunciator LB-11<br>"PRESSURIZER LO-LO<br>LEVEL CHANNEL Y"   | Sensing Element listed<br>as LC-1110X                                    | Sensing Element<br>should be LA-1110X  |

|  |   |   |  |
|--|---|---|--|
|  | Annunciator LB-12<br>"ATM STM DUMP MV-<br>08-19A/19B<br>OVERLOAD/SS ISOL" | Indicated conditions,<br>CWD reference and<br>sensing element | This indicated<br>condition and<br>contacts were<br>removed by PC/M<br>275-290, closed<br>10/28/92 |
| Drawing 2998-B-327<br>Sheet 211, Rev 14,<br>"Component Cooling<br>Water Shutdown Heat<br>Exch & Surge Tank Fill<br>Valves" |   | Does not show which<br>LA annunciator alarms<br>from LS-14-1A |  |
| 2998-B-327<br>Sheet 1142, Rev 7,<br>"Plant Auxiliaries<br>Control Board<br>Annunciator - LA"                               | Annunciator LA-9  | Sensing Element<br>specified as LS-17-<br>552A, 553A          | Sensing Element<br>should be LS-59-<br>009A, 14A   |
| 2998-B-327<br>Sheet 1143, Rev 7,<br>"Plant Auxiliaries<br>Control Board<br>Annunciator - LB"                               | Annunciator LB-9  | Sensing Element<br>specified as LS-17-<br>552B, 553B          | Sensing Element<br>should be LS-59-<br>021B, 028B  |

The inspector noted that the errors above were additional examples of errors identified in previous inspection reports which had been documented under URI 96-04-05, "Configuration Control Management." The inaccuracies noted were consistent with inaccuracies identified in previous, similar, walkdowns. The inspector noted that two inaccuracies (annunciators LA-12 and LB-12) were clearly the result of the inadequate implementation of the design change process. These inaccuracies are discussed in the context of other, similar, inaccuracies in paragraph E7.1, below.

#### c. Conclusions

The inspectors concluded the following with respect to annunciator panels LA and LB for the PACB:

- Annunciator response procedure inaccuracies existed of the same types identified in previous, similar, walkdowns.
- In the cases of two annunciator windows, the inaccuracies were identified to be the result of inadequate implementation of the design change process.

#### E7.2 PC/M Execution Issues (71707, 37551, 92901, 92903)

##### a. Inspection Scope

Inspection Report (IR) 96-04 identified several potential configuration control weaknesses involving inaccuracies in control room annunciator response summaries and engineering drawings. Of the deficiencies noted, one was tied to an inadequacy in the implementation of a PC/M. URI 96-04-05, "Configuration Control Management," was opened to track the issue while the inspection scope was expanded. IR 96-06 documented additional deficiencies, identified during system walkdowns, which were the result of PC/M implementation inadequacies. During the current inspection period, two additional PC/M implementation issues were identified; one, involving inaccuracies in annunciator response summaries, is described in paragraph E7.1, above; one, involving licensee-identified procedural inadequacies, is described below. The inspectors performed a review of the relevant inspection findings in an attempt to characterize the identified issues.

#### b. Findings

The inspectors reviewed issues identified under URI 96-04-05, "Configuration Control Management." IR 96-06 summarized recent NRC findings in the area of inaccuracies in plant procedures and drawings and stated that ten examples of alarm setpoint inaccuracies and 18 other (e.g. wrong sensing element, wrong action directed) inaccuracies in the Annunciator Response Summaries had been identified in both units' ICW and CS systems. The inspectors reviewed findings generated in IRs 96-04, 96-06, and the current reporting period to identify examples which demonstrated that design changes made to the plant resulted, through inadequate implementation, in such inaccuracies. As a result, the inspectors identified the following items:

- 1) IR 96-04 documented the fact that, on January 6, 1995, the licensee closed out PC/M 109-294 [Setpoint change to the Hydrazine Low Level Alarm (LIS-07-9)] without assuring that affected procedure ONOP 2-0030131, "Plant Annunciator Summary," was revised. This resulted in annunciator S-10, "HYDRAZINE TK LEVEL LO," showing an incorrect setpoint of 35.5 inches.
- 2) IR 96-06 documented the fact that, on May 16, 1994, the licensee closed out PC/M 341-192 [ICW Lube Water Piping Removal and CW Lube Water Piping Renovation]. The as-built Dwg. No. JPN-341-192-008 was not incorporated in Dwg. No. 8770-G-082, "Flow Diagram Circulating and Intake Cooling Water System," Rev 11, sheet 2, issued May 9, 1995, for PC/M 341-192. This resulted in Dwg. No. 8770-G-082 erroneously showing valves I-FCV-21-3A & 3B and associated piping still installed.
- 3) IR 96-06 documented the fact that, on February 14, 1994, the licensee closed out PC/M 268-292 [ICW Lube Water Piping Removal and CW Lube Water Piping Renovation] without assuring that affected procedure ONOP 2-0030131, "Plant Annunciator Summary," was revised. This resulted in annunciator E-16, "CIRC WTR PP LUBE WTR SPLY BACKUP IN SERVICE," incorrectly requiring operators to verify the position of valves MV-21-4A & 4B following a Safety



Injection Actuation System (SIAS) signal using control room indication. These valves no longer received a SIAS signal, were deenergized and had no control room position indication.

- 4) This inspection report (paragraph E7.1) documents the fact that, on October 28, 1992, the licensee closed out PC/M 275-290 [FIS-14-6 Low Flow Alarm and "Manual" Annunciator Deletions] without assuring that affected procedure ONOP 2-0030131, "Plant Annunciator Summary," was revised. This resulted in safety-related annunciators LA-12, "ATM STM DUMP MV-08-18A/18B OVERLOAD/SS ISOL," and "LB-12 ATM STM DUMP MV-08-19A/19B OVERLOAD/SS ISOL," incorrectly requiring operators to check the Auto/Manual switch or switches at RTGB-202 and PACB for the MANUAL position. The relay contacts which energized these annunciators based on switch position were removed to eliminate nuisance alarms.

In addition to these findings, the licensee identified one example of a failure to include operational limitations imposed by a calculation in a plant procedure:

- 5) During the current inspection period, the licensee identified the fact that assumptions made in the heat load calculation supporting the Unit 1 full core offload were not appropriately factored into the applicable procedure. Specifically, PC/M 054-196, supplement 0, "St. Lucie Unit 1 Cycle 14 Reload," included, in Attachment 8, operational limitations which resulted from the heat load calculation performed to support the full core offload. These included:
- Ensuring that initial Spent Fuel Pool (SFP) temperature was less than or equal to 106°F.
  - Ensuring that the reactor was subcritical for at least 168 hours prior to commencing the offload.
  - Verifying that the SFP high temperature alarm, which annunciated in the control room, was operable.
  - Verifying that two SFP cooling pumps were in operation.
  - Verifying that Component Cooling Water (CCW) flow to the fuel pool heat exchangers was maintained at approximately 3560 gpm when two SFP cooling pumps were operating.

On May 12, the licensee's Quality Assurance (QA) organization identified the fact that these limitations were not included in OP 1-1600023, "Refueling Sequencing Guidelines." The offload of seven fuel assemblies had occurred by the time the deficiencies were identified. The defueling evolution was subsequently stopped, and the prerequisites were added to OP 1-1600023,

"Refueling Sequencing Guidelines," as revision 62 to the procedure.

10 CFR 50 Appendix B, Criterion III, "Design Control," requires, in part, that measures be established to ensure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The licensee's Topical Quality Assurance Report, TQR 3.0, Rev 11, "Design Control," included the following provisions:

- Section 3.2.2, "Design Change Control," stated, in part, "Design changes shall be reviewed to ensure that implementation of the design change is coordinated with any necessary changes to operating procedures..."

- Section 3.2.4, "Design Verification," stated, in part, that "Design control measures shall be established to independently verify that design inputs, design process, and that the design inputs are correctly incorporated into design output."

The inspectors concluded that the examples cited above failed to meet the criteria of 10 CFR 50 Appendix B and the licensee's QA program. The inspectors found that the number of examples identified indicated that a programmatic flaw existed in the licensee's program for ensuring that material changes to the plant were reflected properly in engineering drawings and plant procedures. As such, the issues above were found to constitute five examples of one apparent violation (EEI 50-335,389/96-12-05, "Failure to Ensure Configuration Control," EA 96-249).

The licensee's QA organization performed an audit of this area and documented their findings in QSL-PCM-96-11, "PC/M Design Control." The licensee found the following with regard to the process:

- Plant procedures and instructions did not adequately define the review and comment process by plant departments impacted by PC/Ms or the resolution to those comments.
- Plant procedures and instructions did not adequately address the identification of plant procedures impacted by PC/Ms.
- Plant procedures and instructions did not adequately address the review of Safety Evaluations for impact on plant procedures and instructions (this applied to Safety Evaluations which included conditions to ensure that the assumptions in the evaluations were maintained valid).

The inspectors found the licensee's findings to be in general agreement with observations made by the NRC.

In response to the issue, the licensee adopted corrective actions which included:

- Implementing design control processes from Turkey Point, which provided more positive control over the initial reviews and documentation of required actions for PC/Ms.
- Performing reviews of all Unit 1 outage related PC/Ms to ensure that required procedural changes were identified.
- Requiring that all PC/M paperwork for modifications installed during the current Unit 1 outage be closed out prior to returning the affected system to service.
- Revalidating open items from previous PC/Ms on both units and establishing timelines for closure of the open items.

- Initiating a vertical slice inspection of selected, PRA-significant systems to ensure that the systems were properly installed and that procedures were adequate.

The inspector reviewed the results of the vertical slice inspections referenced above, performed on the EDG, High Pressure Safety Injection (HPSI), and CCW systems. The results were documented in CRs 96-1588 (Unit 1 items for Operations disposition), 96-1589 (Unit 1 items for Engineering disposition), 96-1360 (Unit 2 items for Operations disposition) and 96-1361 (Unit 2 items for Engineering disposition). In general, the licensee's findings were consistent with NRC findings in this area and included cases in which procedure-to-drawing deviations existed in valve position, cases of annunciator response summary errors existed, cases of instrument range differences between the UFSAR and design documents, and cases of configuration differences between the plant and design documents.

The inspectors found that the licensee had initiated actions to address the PC/M issues discussed above and to ensure that the as-built configuration of the plant was adequate. The overall adequacy of the licensee's actions will be determined in followup inspections to the apparent violations described above.

URI 96-04-05, "Configuration Control Management," is closed.

#### c. Conclusions

The inspectors concluded the following with respect to configuration controls:

That programmatic flaws resulted in one apparent violation involving the issue of configuration management and the licensee's ability to correctly translate design changes into drawings and procedures. The apparent violation included five examples:

- 1) One example of a failure to update an annunciator response summary when a hydrazine tank low level alarm setpoint was changed via PC/M.
- 2) One example of a failure to update an engineering drawing to reflect the addition, via PC/M, of valves and piping for the Intake Cooling Water System.
- 3) One example of a failure to update an annunciator response summary to reflect a change, made via PC/M, which removed automatic and control room operation capability from a pair of valves.
- 4) One example of a failure to update an annunciator response procedure to reflect a change, made via PC/M, which removed the alarm function from an annunciator.

- 5) One licensee-identified example of a failure to update an operating procedure to include operational limitations imposed by a PC/M-transmitted spent fuel pool heat load calculation.

The licensee's QA organization was identifying specific areas of concern in the configuration management area. The licensee had initiated actions to address the configuration management deficiencies identified by both the NRC and the licensee's QA organization.

#### V. Management Meetings and Other Areas

##### X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on July 12. The licensee acknowledged the findings presented.

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

## PARTIAL LIST OF PERSONS CONTACTED

Licensee

Bladow, W., Site Quality Manager  
Bohlka, W., Vice President, Engineering  
Burton, C., Site Services Manager  
Dawson, R., Business Manager  
Denver, D., Site Engineering Manager  
Fulford, P., Operations Support and Testing Supervisor  
Holt, J., Information Services Supervisor  
Johnson, H., Operations Manager  
Scarola, J., St. Lucie Plant General Manager  
Weinkam, E., Licensing Manager

Other licensee employees contacted included operations, engineering, maintenance, and corporate personnel.

## INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering  
 IP 64704: Fire Protection Program  
 IP 71707: Plant Operations  
 IP 92901: Followup - Plant Operations  
 IP 92903: Followup - Engineering

## ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

|                     |     |  |
|---------------------|-----|--|
| 50-389/96-12-01     | EEI | Failure to Perform a 10 CFR 50.59 Safety Evaluation for CEDMCS Enclosure                     |
| 50-335,389/96-12-02 | EEI | Failure to Perform a 10 CFR 50.59 Safety Evaluation For Use of a Temporary Fire Pump         |
| 50-335/96-12-03     | EEI | Failure to Perform a 10 CFR 50.59 Safety Evaluation For Change in Setpoints Listed in UFSAR. |
| 50-389/96-12-04     | EEI | Unreviewed Safety Question Involving EDG 2B  |
| 50-335,389/96-12-05 | EEI | Failure to Ensure Configuration Control  |

Closed

|                     |     |                                  |
|---------------------|-----|----------------------------------|
| 50-335,389/96-04-05 | URI | Configuration Control Management |
|---------------------|-----|----------------------------------|

Discussed

|                     |     |                         |
|---------------------|-----|-------------------------|
| 50-335,389/96-04-07 | URI | Failure to Update UFSAR |
|---------------------|-----|-------------------------|

## LIST OF ACRONYMS USED

|        |   |
|--------|---|
| ATTN   | Attention   |
| CCW    | Component Cooling Water                                   |
| CEDMCS | Control Element Drive Mechanism Control System            |
| CFR    | Code of Federal Regulations                               |
| CR     | Condition Report  |
| CW     | Circulatory Water   |
| DFOST  | Diesel Fuel Oil Storage Tank                              |
| D^R    | Demonstration Power Reactor (A type of operating license) |
| DWG    | Drawing   |
| EA     | Enforcement Action  |
| EDG    | Emergency Diesel Generator                                |
| EEI    | Escalated Enforcement Item                                |
| FIS    | Flow Indicator/Switch                                     |
| FO     | Fuel Oil  |
| FPL    | The Florida Power & Light Company                         |
| FRG    | Facility Review Group                                     |
| gpm    | Gallon(s) Per Minute (flow rate)                          |
| HPSI   | High Pressure Safety Injection (system)                   |
| ICW    | Intake Cooling Water                                      |
| IR     | [NRC] Inspection Report                                   |
| JPN    | (Juno Beach) Nuclear Engineering                          |
| LIS    | Level Indicating Switch                                   |
| MV     | Motorized Valve   |
| NLO    | Nor-Licensed Operator                                     |
| No.    | Number  |
| NPF    | Nuclear Production Facility (a type of operating license) |
| NRC    | Nuclear Regulatory Commission                             |
| NUREG  | Nuclear Regulatory (NRC Headquarters Publication)         |
| ONOP   | Off Normal Operating Procedure                            |
| OP     | Operating Procedure                                       |
| PACB   | Plant Auxiliary Control Board                             |
| PC/M   | Plant Change/Modification                                 |
| PDR    | NRC Public Document Room                                  |
| PM     | Preventive Maintenance                                    |
| PRA    | Probabilistic Risk Assessment                             |
| PSL    | Plant St. Lucie   |
| QA     | Quality Assurance   |
| QI     | Quality Instruction                                       |
| QSL    | Quality Surveillance Letter                               |
| SAR    | Safety Analysis Report                                    |
| SE     | Safety Evaluation   |
| SFP    | Spent Fuel Pool   |
| SIAS   | Safety Injection Actuation System                         |
| SIT    | Safety Injection Tank                                     |
| St.    | Saint   |
| TQR    | Topical Quality Requirement                               |
| UFSAR  | Updated Final Safety Analysis Report                      |
| URI    | [NRC] Unresolved Item                                     |
| USNRC  | United States Nuclear Regulatory Commission               |
| USQ    | Unreviewed Safety Question                                |