



**UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
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ATLANTA, GEORGIA 30303-8931**

October 28, 2002

Florida Power and Light Company
ATTN: Mr. J. A. Stall, Senior Vice President
Nuclear and Chief Nuclear Officer
P. O. Box 14000
Juno Beach, FL 33408-0420

**SUBJECT: ST. LUCIE NUCLEAR PLANT - NRC INTEGRATED INSPECTION REPORT
50-335/02-03 AND 50-389/02-03**

Dear Mr. Stall:

On September 28, 2002, the NRC completed an inspection at your St. Lucie Units 1 and 2. The enclosed report documents the inspection findings which were discussed on October 1, 2002, with Mr. R. Rose and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

This report documents one NRC identified finding of very low safety significance (Green). This issue was determined to involve a violation of NRC requirements. However, because of the very low safety significance and because it has been entered into your corrective action program, the NRC is treating this issue as a non-cited violation, in accordance with Section VI.A of the NRC's Enforcement Policy. If you contest this non-cited violation, you should provide a response, within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the St. Lucie facility.

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Sincerely,

//RA//

Leonard D. Wert, Chief
Reactor Projects Branch 3
Division of Reactor Projects

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

Enclosure: Inspection Report 50-335/02-03, 50-389/02-03
w/Attachment - Supplemental Information

cc w/encl: (See page 3)

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cc w/encl:
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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.: 50-335, 50-389

License Nos.: DPR-67, NPF-16

Report Nos.: 50-335/02-03, 50-389/02-03

Licensee: Florida Power & Light Company (FPL)

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

Location: 6351 South Ocean Drive
Jensen Beach, FL 34957

Dates: June 30 through September 28, 2002

Inspectors: T. Ross, Senior Resident Inspector
D. Lanyi, Resident Inspector
C. Patterson, Senior Resident Inspector Turkey Point
S. Rudisail, Project Engineer
R. Reyes, Resident Inspector Turkey Point
S. Sanchez, Resident Inspector, Crystal River
J. Wallo, Physical Security Inspector (Sections 3PP1 and 3PP2)

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

Enclosure

SUMMARY OF FINDINGS

Inspection Report 05000335-02-03, 05000389-02-03, Florida Power & Light, on 06/30-9/28/2002, St. Lucie Nuclear Plant, Units 1 & 2. One finding in area of Access Control.

This inspection was conducted by the St. Lucie resident inspectors, several resident inspectors from other sites, and three region based inspectors. One finding of very low safety significance (Green) was identified in the Access Control area. The significance of issues is indicated by their color (Green, White, Yellow, Red) and was determined by the Significance Determination Process in the NRC Inspection Manual Chapter 0609. Findings to which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

A. Inspector Identified Findings

Cornerstone: Physical Protection

Green. A non-cited violation was identified for the licensee's failure to comply with Section 4.5.3 of the Physical Security Plan. On August 14, 2002, security personnel, performing access control duties, permitted a visitor to enter the protected area, and subsequently proceed to the South Service Building (SSB), without an escort.

This finding was evaluated using the Physical Protection Significance Determination Process and determined to be of very low safety significance. The finding was a vulnerability in access control that did not involve a malevolent act, and there had not been two similar findings in four quarters. (Section 3PP2)

B. Licensee Identified Violations

None

Report Details

Summary of Plant Status

Both units operated at essentially full power for the entire report period, except that Unit 1 reduced power to 45 percent on September 27 in preparation for a scheduled refueling outage.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity (Reactor - R)

1R04 Equipment Alignment

.1 Partial Equipment Walkdowns

a. Inspection Scope

The inspectors conducted partial alignment verifications of the safety related systems listed below to review the operability of required redundant trains or backup systems while the other trains were inoperable or out of service. These inspections included reviews of plant lineup procedures, operating procedures, and piping and instrumentation drawings which were compared with observed equipment configurations to identify any discrepancies that could affect operability of the redundant train or backup system.

- 1A Emergency Core Cooling Systems (ECCS)
- 2B Component Cooling Water (CCW) System
- 1B High Pressure Safety Injection (HPSI) and Containment Spray (CS) Systems

b. Findings

No findings of significance were identified.

1R05 Fire Protection

.1 Routine Inspections

a. Inspection Scope

The inspectors conducted tours of the fire areas and/or witnessed associated activities listed below to verify whether they conformed with Administrative Procedure AP-1800022, Fire Protection Plan. The inspectors specifically examined any transient combustibles in the areas and any ongoing hot work or other potential ignition sources. The inspectors also assessed whether the material condition, operational status, and operational lineup of fire protection systems, equipment and features were in accordance with the Fire Protection Plan. Furthermore, the inspectors evaluated the use of any compensatory measures being performed in accordance with the licensee's procedures and Fire Protection Plan.

- 1A Intake Cooling Water (ICW) hot work
- Unit 1 and 2 Auxiliary Feedwater (AFW) pump rooms

- Fire House and fire brigade protective equipment storage cabinets
- 2B Emergency Diesel Generator (EDG)

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification

a. Inspection Scope

During the weeks of July 11 and 18, 2002, the inspectors observed and assessed licensed operator simulator training for emergency response actions required to be taken during a security threat involving a simulated serious loss of critical safety equipment. The inspectors specifically evaluated the following attributes related to operating crew performance:

- Clarity and formality of communication
- Ability to take timely action to safely control the unit
- Prioritization, interpretation, and verification of alarms
- Correct use and implementation of emergency procedures, in particular the safeguards contingency response procedure guidelines developed for Operations to be used in concert with the Emergency Operating Procedures and Emergency Plan Implementing Procedures (EPIP)
- Coordination with Security personnel
- Control board operation and manipulation, including high-risk operator actions
- Oversight and direction provided by the shift supervisor, including ability to identify and implement appropriate TS actions, regulatory reporting requirements, and emergency plan actions and notifications
- Effectiveness of the post training critique

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

.1 Routine Inspection

a. Inspection Scope

The inspectors evaluated the multiple Unit 2 Charging pump failures to assess the effectiveness of licensee efforts in accordance with Administrative Procedure ADM-17.08, Implementation of 10 CFR 50.65, The Maintenance Rule, and 10CFR50.65. The inspectors' efforts focused on maintenance rule scoping, characterization of the failed components, risk significance, determination of a(1) classification, corrective actions, and the appropriateness of established performance goals and monitoring criteria. The inspectors also attended applicable expert panel meetings, interviewed responsible engineers, and observed corrective maintenance activities. Furthermore, the inspectors

verified whether equipment problems were being identified at the appropriate level and entered into the corrective action program.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

The inspectors reviewed and witnessed the following planned online maintenance activities to evaluate the effectiveness of licensee scheduling, configuration control, and management of online risk in accordance applicable program procedures such as ADM 17.16, Implementation of the Configuration Risk Management Program, and ADM 10.01, Critical Maintenance Management (CMM). The inspectors also examined whether appropriate contingencies were taken to reduce risk and minimize unavailability, and that emergent work activities were properly planned per ADM-10.03, Work Week Management. The inspectors confirmed that problems with maintenance, risk assessments and emergent work were identified and appropriately addressed by the corrective action program.

- 1C AFW pump CMM
- 1B ECCS CMM
- 2A CCW CMM
- 1A ECCS CMM
- 1A AFW CMM
- 1B Startup Transformer breaker CMM

b. Findings

No findings of significance were identified.

1R14 Personnel Performance During Nonroutine Plant Evolutions And Events

a. Inspection Scope

For the period of September 18 through September 27, the inspectors observed operator performance during the conduct of an end-of-cycle Tavg coastdown of Unit 1 in accordance with Operating Procedure (OP) 0110058, Coastdown. The inspectors evaluated operator actions pursuant to applicable procedures and Technical Specifications (TS), including a detailed guidance memo from the reactor engineering department. The inspectors also examined plant conditions and indicated parameters; reviewed operator logs; and, interviewed responsible reactor engineers and operators. Furthermore, the inspectors reviewed Operations conduct of OP 1-3200020, Primary System Manual Calorimetric, and 1-OSP-69.01, Nuclear and Delta-T Power Calibration.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed the interim disposition and operability determinations associated with the following CRs to ensure that TS operability was properly supported and the SSC remained available to perform its safety function with no unrecognized increase in risk. The inspectors reviewed the UFSAR, applicable supporting documents and procedures, and interviewed plant personnel to assess the adequacy of the interim CR disposition.

- CR 02-1882 2A Charging pump discharge valve spring failure
- CR 02-1718 2A CCW heat exchanger tube plugging limit exceeded
- CR 02-0212 Refueling Water Tank (RWT) degraded drain valve

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed post maintenance test (PMT) procedures and witnessed testing activities after maintenance of selected risk significant SSCs listed below. The following aspects were specifically inspected - (1) Effect of testing on the plant recognized and addressed by control room and/or engineering personnel; (2) Testing consistent with maintenance performed; (3) Acceptance criteria demonstrated operational readiness consistent with design and licensing basis documents such as TS, UFSAR, and others; (4) Range, accuracy and calibration of test equipment; (5) Step by step compliance with test procedures, and applicable prerequisites satisfied; (6) Control of installed jumpers or lifted leads; (7) Removal of test equipment; and, (8) Restoration of SSCs to operable status. The inspectors also reviewed problems associated with PMTs to ensure that they were correctly identified and appropriately entered into the corrective action program.

- OP 1-0410050, 1B HPSI and 1B Low Pressure Safety Injection (LPSI) Periodic Test
- OP 1-0420050, 1B CS Periodic Test
- OP 1-0410050, 1A HPSI/LPSI Periodic Test
- OP 1-0420050, 1A CS Periodic Test
- OP 1-0700050, 1A AFW Periodic Test
- OP 1-0010125, Unit 1 ECCS room safeguards fan (HVE-9A) Periodic Test

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors reviewed and witnessed the conduct of the surveillance tests listed below in accordance with applicable operating procedures (OP), Instrumentation and Control Maintenance Procedure (IMP), operations surveillance procedures (OSP), and Instrumentation and Control procedures (ICP). Applicable test data was reviewed to verify whether it met TS, UFSAR, and/or licensee procedure requirements. The inspectors also verified that the testing effectively demonstrated the systems were operationally ready, capable of performing their intended safety functions, and that identified problems were entered into the corrective action program for resolution.

- OP 1-0700050, 1C AFW Periodic (Inservice) Test
- OP 2-2200050B, 2B EDG (fast start) Periodic Test
- OP 1-2200050B, 1B EDG (monthly) Periodic Test

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed Temporary System Alteration (TSA) # 1-02-004 that was used to replace a failed safety channel D linear power range excore neutron detector with an excore detector connected to the reactor regulating system. The inspectors also reviewed TSA# 2-02-005 that was used to modify the ventilation flow balance in the cable spreading room (CSR) to reduce the differential pressure between the CSR and main control room. The inspectors evaluated these temporary modifications and associated 10 CFR 50.59 screenings against the system design basis documentation to ensure that (1) the modification did not adversely affect operability or availability of other systems and (2) the installation was consistent with applicable modification documents. The inspectors also walked down the installation of each TSA to verify configuration control.

b. Findings

No findings of significance were identified.

Cornerstone: Emergency Preparedness (EP)

EP6 Drill Evaluation

a. Inspection Scope

On August 13, 2002, the inspectors monitored the participation of an operating crew in the simulator during the third quarter EP drill of the site emergency response organization. During this drill the inspectors assessed operator actions in the control

room simulator to verify whether emergency classification, notification, and protective action recommendations were made in accordance with implementing procedures. Additionally, the inspectors evaluated the adequacy of the post drill critiques conducted in the simulator, and verified whether CRs were initiated for identified problems.

b. Findings

No findings of significance were identified.

3. SAFEGUARDS
Cornerstone: Physical Protection (PP)

3PP1 Access Authorization (Behavior Observation Program)

a. Inspection Scope

The inspectors evaluated the licensee's behavioral observation program to determine the effectiveness and proper implementation of the behavioral observation portion of the personnel screening and fitness for duty (FFD) program. Three representatives of licensee management and three employees assigned escort duties were interviewed to determine their understanding of the behavior observation program. The inspectors evaluated the effectiveness of each individual's training, including their ability to recognize aberrant behavioral traits, indications of narcotic and alcohol use, and knowledge of work call-out reporting procedures.

The inspectors reviewed the licensee's Fitness for Duty reports provided to the NRC for the period August 2001 through August 2002, and a sample of the licensee's Condition Reports (CRs) and Safeguards Event Logs for the period January through September 2001 and January through July 2002, to evaluate the licensee's threshold for recommending for-cause testing for events related to human performance. In addition, the licensee's procedures and controls used by supervisors to determine whether employees were continuously observed in accordance with the established continual behavior observation program were reviewed and discussed with the Access Authorization Manager.

The licensee's activities were evaluated against requirements in the St. Lucie Nuclear Plant Physical Security Plan (PSP), Procedure NP-400, Behavioral Observation and Fitness for Duty, and 10 CFR Part 26, Fitness For Duty Program.

b. Findings

No findings of significance were identified.

3PP2 Access Control

a. Inspection Scope

The effectiveness of the licensee's access control procedures and associated equipment designed to detect and prevent the introduction of contraband into the protected area (PA) were evaluated. The inspectors observed and evaluated the

adequacy of the testing procedures performed by a licensee security representative on in-use access control equipment and on in-service standby equipment at the site's primary personnel access portal. The equipment testing procedure was reviewed to determine if testing was performance based and challenged the installed and configured site equipment. Through observation of licensee performance testing, the inspectors assessed the adequacy of the card readers and biometric hand readers located at the primary personnel access portal to prevent unauthorized entry into the protected area and to preclude multiple entries without logging out of the protected area. The inspector also observed and evaluated in-processing searches of personnel and packages at the primary personnel access portal and search of vehicles at the sally port on August 27, 2002, for compliance with the PSP.

The licensee's Key and Lock Program and associated procedures for limiting and controlling vital area keys were examined, including key inventories for the first and second quarters of 2002. The inspectors also verified whether employees terminated for cause during the same period prompted changes to combination locks used to secure vital area keys and cores.

The licensee's procedures and processes for granting unescorted access to vital areas were evaluated to determine if access was granted to only those personnel identified as having a need for such access. Recent monthly vital area review documents were evaluated to determine whether supervisors were evaluating employees' need for continued access in accordance with regulatory requirements .

The licensee's activities were evaluated against requirements contained in the St. Lucie PSP; Procedures ADM-1502, Access Authorization and Gate Pass Program, and AP-0006025, Key and Lock Program; Security Force Instruction No. 1, Access Control and Search Equipment Testing; the Site Access Training Manual; 10 CFR 73.55, Requirements for Physical Protection of Licensed Activities in Nuclear Power Reactors Against Radiological Sabotage; and 10 CFR 73.56, Personnel Access Authorization Requirements for Nuclear Power Plants.

b. Findings

Green. A non-cited violation was identified for the failure to provide an escort to a visitor while in the PA on August 14, 2002, as required by Section 4.5.3 of the PSP.

On August 14, 2002, security personnel performing access control duties, permitted a visitor to enter the PA, and subsequently proceed to the South Service Building (SSB), without an escort. Based on discussion with licensee security personnel and a review of pertinent documents, the inspectors determined the following. The visitor, who had been authorized by management, was assisted upon entry at the personnel access portal by a security officer. This officer proceeded to the turnstile with the visitor; however, there was no escort present on the PA side of the turnstile to meet the visitor. Upon being provided an indication by the security officer, a second security officer responsible for final access control permitted entry of the visitor into the PA without verifying his visitor badge or that an escort was in place inside the PA. The first security officer then processed through the turnstile into the PA after the visitor. Once inside the PA, a brief conversation took place between the visitor and a security officer, after which the visitor was permitted to proceed to the SSB unescorted. Quality assurance

personnel observed the visitor without his escort on the fourth floor of the SSB approximately 10 minutes after he entered the PA and placed him under escort control. Subsequently, the licensee logged the event in accordance with 10 CFR 73, Appendix G.II, and clarifications provided in NUREG-1304, Reporting of Safeguards Events, and Generic Letter 91-03, Reporting of Safeguards Events.

The finding is associated with the two failures related to the access control attribute of the Safeguards Cornerstone. Permitting an individual who is not authorized unescorted access to enter and traverse the PA without an escort could adversely affect the licensee's ability to provide adequate assurance that the physical protection system can protect against the design basis threat of radiological sabotage. Using the Physical Protection Significance Determination Process and identifying the issue as a vulnerability in access control, without a malevolent act, and without two similar findings in four quarters, the issue is determined to be of very low safety significance.

License Condition 2.D states, in part, that "the licensee shall fully implement and maintain in effect all provisions of the Commission-approved physical security, guard training and qualification, and safeguards contingency plans including amendments made pursuant to provisions of the miscellaneous amendments and search requirements revisions to 10 CFR 73.55 (51 FR 27817 and 27822) and to the authority of 10 CFR 50.90 and 10 CFR 50.54(p)." The St. Lucie Nuclear Plant PSP, Rev. 58, Chapter 4, Protected Areas, Section 4.5.3 states, in part, that "all authorized visitors shall be escorted to maintain positive control." Contrary to this requirement, on August 14, 2002, the licensee permitted an authorized visitor to enter the PA and proceed to the SSB without an escort. This violation is being treated as a non-cited violation consistent with Section VI.A of the Enforcement Policy and is identified as NCV 50-335,339/2002-03-01, Failure to Provide an Escort for a Visitor in Protected Area. The licensee has entered the issue into their corrective action program as CR 02-1752, dated August 14, 2002.

3PP3 Response to Contingency Events (71130.03)

The Office of Homeland Security (OHS) developed a Homeland Security Advisory System (HSAS) to disseminate information regarding the risk of terrorist attacks. The HSAS implements five color-coded threat conditions with a description of corresponding actions at each level. NRC Regulatory Information Summary (RIS) 2002-12a, dated August 19, 2002, "NRC Threat Advisory and Protective Measures System," discusses the HSAS and provides additional information on protective measures to licensees.

a. Inspection Scope

On September 10, 2002, the NRC issued a Safeguards Advisory to reactor licensees to implement the protective measures described in RIS 2002-12a in response to the Federal government declaration of threat level "orange." Subsequently, on September 24, 2002, the OHS downgraded the national security threat condition to "yellow" and a corresponding reduction in the risk of a terrorist threat.

The inspectors interviewed licensee personnel and security staff, observed the conduct of security operations, and assessed licensee implementation of the threat level

“orange” protective measures. Inspection results were communicated to the region and headquarters security staff for further evaluation.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

40A1 Performance Indicator (PI) Verification

.1 Protected Area Equipment Performance Index, Personnel Screening Program Performance, and Fitness for Duty/Personnel Reliability Program PIs

a. Inspection Scope

The inspector evaluated the licensee’s PI data associated with the Intrusion Detection System (IDS) and Closed Circuit Television (CCTV) to determine if the licensee provided accurate reporting for compensatory time relative to equipment degradation for the PA Equipment Performance Index PI. The evaluation included review of selected tracking and trending reports, security logs, and security event reports for the year of 2001 and the first quarter of 2002. A review of a sample list of licensee event reports and security logs for the same period was also conducted to determine the accuracy of PI data associated with the Personnel Screening Program Performance and Fitness for Duty/Personnel Reliability Program Performance PIs.

b. Findings

No findings of significance were identified.

.2 Mitigating Systems Cornerstone

a. Inspection Scope

The inspectors assessed the accuracy of the Unit 1 and 2 Residual Heat Removal Unavailability performance indicator (PI) reported to the NRC in accordance with the criteria specified in NEI 99-02, Regulatory Assessment Performance Indicator Guideline, and ADM-25.02, NRC Performance Indicators.

The inspectors verified the PI data of both Units 1 and 2 for the previous four quarters. Applicable records were reviewed to verify the reported PI data was complete and accurate. The inspectors also interviewed the responsible system engineer to review the reported PI data.

b. Findings

No findings of significance were identified.

4OA3 Event Follow-up

- .1 (Closed) Licensee Event Report (LER) 50-389/2001-002: As-Found Cycle 12 Main Steam Safety Valve Setpoints Outside Technical Specification Limits. On November 25, 2001, with Unit 2 at 68% power, testing of the main steam safety relief valves found that the setpoints for four valves were outside the Technical Specification (TS) limit of +1% to -3%. Two of the valves were retested and/or adjusted to be within limits. The other two valves remained out of service for scheduled overhaul. The tests were conducted per procedure 2-MSP-08.07, Main Steam Safety Valve Setpoint Surveillance. This procedure requires that the maximum allowable power level-high trip setpoints be reduced based on the number of inoperable safety valves per TS Table 3.7-1. The inspectors verified that the applicable TS action statements were complied with once the conditions were identified. Consequently, no violation of TS action statements occurred. The licensee conservatively assumed the condition to have occurred at an earlier time and thus reported it as a condition outside of TS.

The licensee documented this condition in CR 01-2813. With one exception, the cause of the high settings was determined to be setpoint drift. Setpoint drift is a generic safety issue for safety relief valves. The cause of the one exception was determined to be aging effects. The licensee performed an evaluation and concluded that the as-found settings were within analytical bounds and therefore there was no impact on the health and safety of the public. Previous corrective action for this issue has been to increase the setpoint tolerance from +1% to -1% to +1% and -3% by a TS change (Amendments 166 and 110 dated November 14, 2000). The licensee performed a historical review of previous condition reports and the established preventive maintenance frequency for these safety relief valves. The licensee concluded that the program has generally been effective in preventing valve failures exceeding 3% and no further changes were warranted. This LER is closed.

4OA6 Meetings

- .1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. R. Rose and other members of licensee management on October 1, 2002. An interim exit by a regional security inspector was held on August 30. The licensee acknowledged the findings presented. No proprietary information was identified.

Supplemental Information

A. PARTIAL LIST OF PERSONS CONTACTED

Licensee

G. Bird, Protection Services Manager
R. Coleman, Instrumentation and Controls Department Supervisor
R. De La Espriella, Site Quality Manager
B. Dunn, Site Engineering Manager
R. Hughes, Systems & Component Engineering Manager
D. Jernigan, Site Vice President
J. Kirkpatrick, Maintenance Manager
R. McCullers, Health Physics Supervisor
R. McDaniel, Fire Protection Supervisor
D. Mohre, Maintenance Rule Administrator
T. Patterson, Operations Manager
J. Porter, Operations Support Engineering Manager
A. Pell, Training Manager
R. Rose, Plant General Manager
A. Scales, Operations Supervisor
G. Varnes, Security Supervisor
J. Voorhees, Corrective Action Group Supervisor and Acting Licensing Manager

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

NRC

B. Moroney, NRR Project Manager
E. Brown, NRR Project Manager

B. ITEMS OPENED AND CLOSED

Closed

50-335, 389/2002-03-01	NCV	Failure to Provide an Escort for a Visitor in Protected Area, (Section 3PP2)
50-389/2001-002	LER	As-Found Cycle 12 Main Steam Safety Valve Setpoints Outside Technical Specification Limits (Section 4AO3.1)

Distribution w/encl:
 B. Moroney, NRR
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