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

August 6, 1996

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

SUBJECT: RII-96-A-0056 - PERSONNEL EXECUTED A SWITCHING ORDER AND MANIPULATED EQUIPMENT WITHOUT KNOWLEDGE OF CONTROL ROOM PERSONNEL

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 findings are documented in the enclosures to this memorandum. Enclosure 1 is the Allegation Evaluation Report which summarizes the findings, and the inspection results are documented in Enclosure 2, NRC Inspection Report No. 50-335,389/96-09, paragraph M3.1.

Based on the information provided, we were not able to substantiate the allegation. No violations of regulatory requirements were identified.

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

Enclosures:
1. Allegation Evaluation Report
2. Inspection Report No.
   50-335,389/96-09

Y138

ENCLOSURE 1

ALLEGATION EVALUATION REPORT

ALLEGATION RII-96-0056

PERSONNEL EXECUTED A SWITCHING ORDER AND MANIPULATED EQUIPMENT WITHOUT KNOWLEDGE OF CONTROL ROOM PERSONNEL

ST LUCIE NUCLEAR PLANT

DOCKET NOS. 50-335 AND 50-389

CONCERN:

Employees were improperly assigned a switching order during restart of unit 1 on February 25, 1996. Non-operations personnel manipulated equipment such as inserted trip signals, closed fuses and racked in breakers. The switching order was not performed by bargaining unit personnel.

DISCUSSION:

The inspector reviewed the licensee's procedures for the establishment and control of the interface between Operations and Transmission and Distribution personnel. The inspector reviewed the following procedures:

- AP 0010532, revision 6, "Relay Work Orders"
- Transmission and Distribution (T&D) Procedure 2650, "Interconnected System - Division of Responsibility"

The inspector found that the subject procedures established clear lines of demarkation between T&D and the onsite organization. With respect to AP 0010532:

- Appropriate controls were established for relay work performed by Protection and Control personnel through the Relay Work Order process.

- The procedure required that the Assistant Nuclear Plant Supervisor for an affected unit be notified and that permission be received prior to the commencement of work.

- Controls over the use of vendor technical manuals were consistent with site practice.

With respect to T&D procedure 2650:

- Lines of responsibility and authority were described

- Specific instructions were described for work involving nuclear plants, with requirements for communication with the NPS/ANPS specified.

- Additional instructions were included to accommodate reduced-inventory and mid-loop conditions.

The inspector discussed these controls with Operations personnel and found that, in general, the interface between Operations and T&D had been controlled appropriately. One example of a failure to communicate across organizational boundaries, involving relay work performed on a tagged-out component, was identified. The licensee stated that the issue was resolved through discussions and counseling.

CONCLUSION:

The inspector concluded, that, by the direction of the Nuclear Plant Supervisor, an employee had properly executed an assigned switching order during restart of unit 1 on February 25, 1996. The licensee had appropriately established controls between activities performed by site personnel and those conducted by T&D. Although the concern was not substantiated, there was one example of a failure to communicate across organizational boundaries, involving relay work performed on a tagged-out component, was identified. The licensee stated that the issue was resolved through discussions and counseling. No violations of regulatory requirements were identified. This allegation is considered closed.

Trans insp. report 96-09

M3 Maintenance Procedures and Documentation

M3.1 Plant/Transmission and Distribution Interface (62703)

a. Scope

The inspector reviewed the licensee's procedures for the establishment and control of the interface between Operations and Transmission and Distribution personnel. The inspector reviewed the following procedures:

- AP 0010532, revision 6, "Relay Work Orders"
- Transmission and Distribution (T&D) Procedure 2650, "Interconnected System - Division of Responsibility"

b. Findings

The inspector found that the subject procedures established clear lines of demarkation between T&D and the onsite organization. With respect to AP 0010532:

- Appropriate controls were established for relay work performed by Protection and Control personnel through the Relay Work Order process.
- The procedure required that the ANPS for an affected unit be notified and that permission be received prior to the commencement of work.
- Controls over the use of vendor technical manuals were consistent with site practice.

With respect to T&D procedure 2650:

- Lines of responsibility and authority were described
- Specific instructions were described for work involving nuclear plants, with requirements for communication with the NPS/ANPS specified.
- Additional instructions were included to accommodate reduced-inventory and mid-loop conditions.

The inspector discussed these controls with Operations personnel and found that, in general, the interface between Operations and T&D had been controlled appropriately. One example of a failure to communicate across organizational boundaries, involving relay work performed on a tagged-out component, was identified. The licensee stated that the issue was resolved through discussions and counseling.

c. Conclusion

The inspector concluded that the licensee had appropriately established controls between activities performed by site personnel and those conducted by T&D.

M8 Miscellaneous Maintenance Issues

M8.1 Violation 335/95-15-03 Issues Revisited (62703)

a. Scope

IR 96-04 closed violation 335/95-15-03, which was issued in response to operator failures to log valve position deviations properly. The issue involved floor drain valves HCV-25-1/7, which were closed and not logged. The valves' closure complicated a loss of RCS inventory event on August 10, 1995, when water issuing from an open relief valve collected in the Unit 1 pipe tunnel, rather than draining through the floor drain system (see IR 95-20).

In closing the subject violation, the inspector noted that the valves had been left closed after difficulties encountered while stroking them in preparation for Hurricane Erin. The inspector reviewed the work packages generated in the repair of the valves and reported that all work appeared to have been performed properly and that appropriate post-maintenance testing had been performed.

During the current inspection period, the inspector reviewed CR 96-1183, which was issued by the licensee's QA organization to document the fact that the subject valves may not have been properly tested after rework. The issue involved the fact that the valves' actuators had been removed in support of correcting the sticking conditions described above. QA indicated, in the CR, that proper post maintenance testing may not have been performed on the part of I&C personnel (the inspector's reviews, referred to above, were of Mechanical Maintenance activities). Specifically, PWO 63/3836 required that HCV-25-1 be retested using Appendix C-3 of QI 11-4 (which required a calibration of the valve), but no such record existed in the archived work package.

The CR referred to PWO 63/3836, which reported that valve HCV-25-1 was sticking in the open position. The inspector reviewed the subject PWO, as well as PWOs 63/2537 (which addressed repairing sticking on HCV-25-4) and 63/4171 (which directed the replacement of the solenoid valve on HCV-25-4). The inspector found that the CR had correctly identified the fact that the retest specified in step 4 of the subject PWO (valve calibration) had not been performed. Rather, records of a functional test (which, basically, cycled the valve to verify proper operation) were included in the package. As corrective action, the licensee specified that the calibrations of HCV-25-1/7 were to be completed satisfactorily (PWO 96011562 and PMAI 96-070112). The inspector noted that AP 0010432, revision 84 (in affect at the time of the work),

WEEKLY BRANCH CHIEF STATUS REPORT

BRANCH 3 SIGNATURE Kerry D. Landis DATE 8/15/96

PLANT ISSUES/EVENTS:

a) St Lucie - Both units are operating at 100%. There was an event involving tampering with key lock switches (see attached PN's).

b) Crystal River - The unit is operating at 100% power. There were two unrelated security problems, one dealt with inadequate compensatory measures during modification work on the security system. For approximately 44 hours the licensee did not take appropriate compensatory measures. The other security issue dealt with loss of visitor control which was identified by the Resident Inspector.

On 8/13/96 there was an OSHA exit regarding personnel protection. There were no immediate safety concerns, there was one apparent citation dealing with the personnel protection around moving machinery, the report will be issued shortly.

c) Turkey Point - Both units are operating at 100%. The licensee and customs officials used drug sniffing dogs to conduct a thorough search of the controlled area of the plant. There was no contraband found. SALP period ends August 17, 1996. Johns Jaudon is onsite August 15 for pre-SALP visit. The SALP Board meeting is scheduled for September 4, 1996.

SIGNIFICANT INSPECTION FINDINGS/INITIATIVES:

a) Crystal River - The HQ lead IPAP inspection report is due out before the 8/28/96 MCAP meeting onsite.

b) The licensee discovered that St. Lucie unit 2 had misaligned PASS valves following routine sampling. During a review of the panel the Resident Inspector discovered an additional mispositioned valve. The alignment was corrected and a Condition Report was initiated.

NRC PERSONNEL ISSUES/STATUS:

a) Son Ninh is being approved for transfer from NRR to RII as a project engineer for Branch 3 assigned to FPL.

b) Credit Hours authorized: None

c) Edwin Lea one year rotation to Watts Bar will begin on October 14, 1996.

d) The Crystal River SRI selection is pending.

ISSUES/ACTIVITIES EXPECTED NEXT WEEK:

Crystal River - 8/19/96 Employee Concerns
8/21/96 FPC Management meeting with NRR to discuss ISI issues.
St Lucie - 8/19/96 Maintenance Inspection

Y139