

**From:** Anne Boland, NRC:R2  
**To:** WND2.WNP6.OEMAIL, ATP1.AFG, JRJ, CFE, BXU, WJM1, A...  
**Date:** 7/8/96 4:30pm  
**Subject:** Region II Enforcement Panel

AI Gibson, NRC:R2  
Tom Johnson, NRC:R2  
Carolyn Evans, NRC:R2  
Bruce Urye, NRC:R2  
William McElroy, NRC:R2

The Region II Weekly Enforcement Panel will be held on July 10, 1996 at 2:00 p.m. in the DRP conference room. The bridge number is 301-415-7605 (passcode [REDACTED])  
The agenda is as follows:

EP 2

1. St. Lucie - Inadequate Safety Evaluation Program (50.59) - The Enforcement Worksheet and all pertinent material is attached.
2. Profession Service Industries, Inc. - Multiple Transportation Violations - The Enforcement Worksheet and draft NOV are attached separately - OI participation requested.

Information in this record was deleted  
in accordance with the Freedom of Information  
Act, exemptions 2  
FOIA- 96-485

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PDR FOIA  
BINDER96-485 PDR

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# ENFORCEMENT ACTION WORKSHEET

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## INADEQUATE SAFETY EVALUATION PROGRAM

PREPARED BY: John W. York

DATE: July 7, 1996

NOTE: The Branch Chief of the responsible Division is responsible for preparation of this EAW and its distribution to attendees prior to an Enforcement Panel. The Section Chief shall also be responsible for providing the meeting location and telephone bridge number to attendees via e-mail [ENF.GRP, CFE, OEMAIL, JXL, JRG, SHL, LFD; appropriate RII DRP, DRS; appropriate NRR, NMSS]. A Notice of Violation (without "boilerplate") which includes the recommended severity level for the violation is required. Copies of applicable Technical Specifications or license conditions cited in the Notice or other reference material needed to evaluate the proposed enforcement action are required to be enclosed.

This Notice has been reviewed by the Branch Chief or Division Director and each violation includes the appropriate level of specificity as to how and when the requirement was violated.

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Signature

Facility: St. Lucie  
Unit(s): 1 and 2  
Docket Nos: 50-335, 389  
License Nos: DPR-67, NPF-16  
Inspection Report No: 96-??  
Inspection Dates: ??  
Lead Inspector: John York

1. **Brief Summary of Inspection Findings:** [Always include a short statement of the regulatory concern/violation. Reference and attach draft NOV. Then, either summarize the inspection findings in this section or reference and attach sections of the inspection report. Inspectors are encouraged to utilize the Noncompliance Information Checklist provided in Enclosure 4 to ensure that the information gathered to support the violation is complete.]

Four examples were identified for violation of 50.59 requirements:

Example 1-The licensee concluded using PRA techniques that closing a manual valve (because of a leak in the transfer line) to the day tank of the EDG would increase the probability of a failure of the EDG by 6%. However, in considering 50.59 criteria, the licensee concluded no increase in probability of component failure and therefore no Unreviewed Safety Question was identified.

Example 2-An enclosure was fabricated in a safety related area without performing a safety evaluation (50.59), i.e. no seismic analysis, etc.

Example 3-Fire protection plan requires that two 2300 gpm fire pumps be operable at all times. During a refueling outage, electrical configuration was such that one of the pumps was removed from service and a smaller (750 gpm) pump was installed. This violated the fire

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protection configuration in the UFSAR and requires a 50.59 evaluation.

Example 4-The licensee changed the refueling hoist interrupt setpoints with only an engineering analysis. Since the set points were outside the UFSAR values a 50.59 safety analysis was required.

See attached IR feeder and proposed NOV for details.

2. **Analysis of Root Cause:**

Attention to detail, inadequate review of UFSAR in the 50.59 process.

3. **Basis for Severity Level (Safety Significance):** [Include example from the supplements, aggregation, repetitiveness, willfulness, etc.]

The number of examples indicate a programmatic breakdown and lack of management oversight of 50.59 such that a safety concern is present regarding compliance with the requirements of 50.59. Also, a condition existed where a required license amendment was not sought, i.e., an USQ existed and the condition was not sent to the NRC for review.

4. **Identify Previous Escalated Action Within 2 Years or 2 Inspections?**  
[by EA#, Supplement, and Identification date ]

None identified?

5. **Identification Credit?** Depends on the example.

Item 1-Inspectors identified that the licensee did not identify an Unreviewed Safety Question. (No)

Item 2-In response to an alarm and related maintenance, the licensee identified that an enclosure in a cable spread room (safety related area) did not have a safety analysis. (No)

Item 3-Inspectors identified and questioned a different size fire pump. (No)

Item 4-Licensee STA and safety committee identified that a 50.59 safety analysis had not been performed. (Yes)

Enter date licensee was aware of issues requiring corrective action:  
[5/96]

6. **Corrective Action Credit?**

Brief summary of corrective actions:

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

A NL Operator was assigned to operate the fuel valve for the EDG and a procedure was changed to indicate the compensatory action. In the other cases the required 50.59 safety analyses have been performed, UFSARs are being changed, and root cause determinations were initiated.

Explain application of corrective action credit:

Corrective action appears to be of appropriate scope.

7. Candidate For Discretion? Yes

Explain basis for discretion consideration:

Licensee's performance has been considered superior in the past.

8. Is A Predecisional Enforcement Conference Necessary? Yes

Why:

To determine adequacy of licensee's proposed long-term corrective actions regarding the 50.59 safety analysis program.

If yes, should OE or OGC attend? [Enter Yes or No]:

Should conference be closed? [Enter Yes or No]:

9. Non-Routine Issues/Additional Information:

This issue should be discussed during a PEC along with the issues panelled the week of July 1.

10. This Action is Consistent With the Following Action (or Enforcement Guidance) Previously Issued: [EICS to provide] [If inconsistent, include:]

Basis for Inconsistency With Previously Issued Actions (Guidance)

11. Regulatory Message:

Control must be maintained over the screening and performance of safety analyses (10 CFR 50.59).

12. Recommended Enforcement Action:

SL III-Under current NUREG 1600 examples I.C.5 and I.C.7 under draft examples I.C.10 and I.C.11.

13. This Case Meets the Criteria for a Delegated Case. [EICS - Enter Yes or No]

14. Should This Action Be Sent to OE For Full Review? [EICS - Enter Yes or No]

If yes why:

15. Regional Counsel Review [EICS to obtain]  
No Legal Objection Dated:

16. Exempt from Timeliness: [EICS]  
Basis for Exemption:

Enforcement Coordinator:  
DATE:

## ENFORCEMENT ACTION WORKSHEET - ISSUES TO CONSIDER FOR DISCRETION

- Problems categorized at Severity Level I or II.
- Case involves overexposure or release of radiological material in excess of NRC requirements.
- Case involves particularly poor licensee performance.
- Case (may) involve willfulness. Information should be included to address whether or not the region has had discussions with OI regarding the case, whether or not the matter has been formally referred to OI, and whether or not OI intends to initiate an investigation. A description, as applicable, of the facts and circumstances that address the aspects of negligence, careless disregard, willfulness, and/or management involvement should also be included.
- Current violation is directly repetitive of an earlier violation.
- Excessive duration of a problem resulted in a substantial increase in risk.
- Licensee made a conscious decision to be in noncompliance in order to obtain an economic benefit.
- Cases involves the loss of a source. (Note whether the licensee self-identified and reported the loss to the NRC.)
- Licensee's sustained performance has been particularly good.
- Discretion should be exercised by escalating or mitigating to ensure that the proposed civil penalty reflects the NRC's concern regarding the violation at issue and that it conveys the appropriate message to the licensee. Explain.

Enclosure 3

REFERENCE DOCUMENT CHECKLIST

- [ ] NRC Inspection Report or other documentation of the case:  
NRC Inspection Report Nos.:
- [ ] Licensee reports:
- [ ] Applicable Tech Specs along with bases:
- [ ] Applicable license conditions
- [ ] Applicable licensee procedures or extracts
- [ ] Copy of discrepant licensee documentation referred to in citations such as NCR, inspection record, or test results
- [ ] Extracts of pertinent FSAR or Updated FSAR sections for citations involving 10 CFR 50.59 or systems operability
- [ ] Referenced ORDERS or Confirmation of Action Letters
- [ ] Current SALP report summary and applicable report sections
- [ ] Other miscellaneous documents (List):

## Safety Evaluations 10 CFR 50.59 Issues

The inspectors reviewed and evaluated other 10 CFR 50.59 safety screenings and safety evaluations but the following four were identified as having problems.

### A. Safety Evaluation for Closing Manual Valve to EDG Fuel Supply

The inspector reviewed the safety evaluation 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 DOST 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 an 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 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.

In the context of regulatory compliance, 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

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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 NRR 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 an Unreviewed Safety Question, as defined in 10 CFR 50.59. Consequently, this action is identified as a violation (VIO 96 XX-ZZ, "Failure to Satisfy Requirements of 10 CFR 50.59").

#### B. Safety Evaluation for CEDMCS Enclosure

On June 4, 1996, a control room annunciator indicated that an undervoltage condition existed on the Control Element Drive Mechanism Control System (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 STA In-House Event Report and Condition Reports 96-1238, 96-1245 and 96-1325 were issued. Some of the following items with appropriate plant corrective action tracking number 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 96-06-208)

As part of the action for Condition Report 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. This testing found that the CEDMCS enclosure required an air conditioned environment to prevent overheating of the four CEDMCS cabinets. The licensee's 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 evaluation provided for the design and installation of the seismic restraints and

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justification of the installation of the CEDMCS enclosure. This air conditioned enclosure was erected during the pre-operational test phase in the early 1980's to provide cooling for the CEA system. However, a 10 CFR 50.59 review was apparently not performed when the enclosure was originally erected. The CEDMCS was described in the UFSAR but the cooling system and enclosure for the CEDMCS were not described in the UFSAR. This was identified as another example of 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 making a change to the plant as described by the UFSAR is identified as a second example of Violation 50-389/96-XX-YY, "Failure to Satisfy the Requirements of 10 CFR 50.59." Also, the failure of the licensee to impose design control measures on the fabrication of the CEDMCS room and its air conditioning system is an additional example of VIO 96-XX-XX, "Failure to Adequately Manage Configuration Control".

### C. Safety Evaluation for Inoperable Fire Pump

During the Spring 1996 Unit 1 refueling outage, one of the two Unit 1 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 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, the end of this inspection period.

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, restore the inoperable equipment to service within seven days or provide an alternate backup pump 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

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an alternate backup pump had not been exceeded. This met the requirements of AP 1800022 for one pump being inoperable.

Resolution of the Condition Report (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 violated the fire protection configuration as described in the UFSAR. An engineering evaluation should have been prepared to justify and document the temporary configuration. This is a third example of Violation 50-335, 389/96-XX-YY, "Failure to Satisfy the Requirements of 10 CFR 50.59".

D. Safety Evaluation for Refueling Equipment Set Points

Condition Report (CR) no.96-812 was issued by the licensee on the safety evaluation number SEFJ-96-020, St Lucie Unit 1 Refueling Equipment Underload and Overload Settings. The report stated that an engineering evaluation had been written to modify the overload and underload setpoints described in the FSAR 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 to 200 pounds (approximately 18 percent for regular fuel assemblies). The original engineering analysis did not take into account that these changes in setpoint values would affect the FSAR and thus the deviation report (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 states in part that the screening process is designed to determine whether the activity requires 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 states 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 violation of procedure which required a safety evaluation (50.59) be performed is a fourth example of Violation 96-XX-YY, "Failure to Satisfy the Requirements of 10 CFR 50.59".

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10 CFR 50.59, "Changes, Tests and Experiments." (a)(1) stated, in part, that a licensee may make changes in the facility as described in the safety analysis report without prior Commission approval, unless the proposed change involves an unreviewed safety question. 10 CFR 50.59 (a)(2) stated, in part, that a proposed change shall be deemed to involve an unreviewed safety question if the probability of occurrence of a malfunction of equipment important to safety previously evaluated in the safety analysis report may be increased. (b)(1) stated, in part, the licensee shall maintain records of changes in the facility to the extent that these changes constitute changes in the facility as described in the safety analysis report or to the extent that they constitute changes in procedures as described in the safety analysis report. These records must include a written safety evaluation which provides the bases for the determination that the change does not involve an unreviewed safety question.

The following four examples of a violation of these requirement were identified.

Example 1-Contrary to the above, in July, 1995, the licensee made a change to the facility which involved an unreviewed safety question when the 2B Emergency Diesel Generator fuel oil line from the fuel oil tank to the day tank was manually isolated to secure a through-wall fuel oil leak. In taking the action, the licensee introduced two failure modes into the 2B Emergency Diesel Generator (operator failure to open a manual isolation valve during a valid demand and the failure of a manual isolation valve to change state during an attempted opening) which necessarily increased the probability of occurrence of a malfunction of the Emergency Diesel Generator above that previously evaluated in the safety evaluation report.

Example 2-Contrary to the above, the licensee erected an enclosure around the Control Element Drive Mechanism Control System during some period around 1984 without performing a safety evaluation. This non-safety related structure was erected in a safety related cable spread room.

Example 3-Contrary to the above, during the 1996 Unit 1 refueling outage with only one operable emergency diesel generator in service, the licensee removed one of the two 2,500 gpm fire pumps from service and installed a temporary 750 gpm fire pump arranged to take suction from fire protection water tank 1B and discharge into the fire protection water system via fire hydrant No. 12 without performing the required safety evaluation. The fire protection water supply system is shared by Units 1 and 2 and is described in UFSAR Appendix 9.5A, Section 3.0.

Example 4-Contrary to the above, the licensee used an engineering evaluation to change the set points and procedures described in the FSAR for operating the fuel hoist without performing a 10 CFR 50.59 safety analysis/evaluation.

UNAUTHORIZED ACCESS OF PERSONNEL  
AFTER TERMINATION

ST. LUCIE

| NAME                  | TERMINATION DATE | LAST ACCESS DATE | DISCOVERY DATE | RESPONSIBLE ORGANIZATION |
|-----------------------|------------------|------------------|----------------|--------------------------|
| <i>Efb</i> [REDACTED] | 7/28/96          | 8/15/96          | 9/15/96        | Engineering              |
| [REDACTED]            | 7/27/96          | 7/27/96          | 9/15/96        | Engineering              |
| [REDACTED]            | 8/24/96          | 7/15/96          | 9/15/96        | Engineering              |

TURKEY POINT

| NAME                  | TERMINATION DATE | LAST ACCESS DATE | DISCOVERY DATE | RESPONSIBLE ORGANIZATION |
|-----------------------|------------------|------------------|----------------|--------------------------|
| <i>Efb</i> [REDACTED] | 3/22/96          | 3/22/96          | 9/17/96        | HR/Juno                  |
| [REDACTED]            | 8/3/96           | 2/29/96          | 10/11/96       | HR/Juno                  |
| [REDACTED]            | 7/12/96          | 4/12/96          | 10/15/96       | HR/Juno**                |

\* Was badged at both PSL and TPN

\*\* Although HR/Juno was the responsible organization, a communication failure occurred in that HR did not notify TPN Security to terminate access. However, the individual's SS# was miscommunicated. When security entered the wrong SS#, the computer noted "no record", which is the same message received when access has been terminated. Therefore, security believed the access had already been turned off.

~~MM/2~~  
mmm/2

UNAUTHORIZED INDIVIDUAL  
ENTERING THE PA AFTER TERMINATION

- 7/28/96 Employee terminated.
- 8/27/96 CR 96-2041 identifies an individual having access to the site, 12 days after termination.
- 9/15/96 PSL Access Coordinator identifies employee terminated and removes the individual's access (along with 2 others), but fails to notify Security.
- 10/7/96 TPN contacts PSL Access Coordinator to process this individual for TPN access.
- 10/9/96 During the processing of this individual, the PSL Access Coordinator notices that the employee's last badge use date is after his termination date. Further review reveals the individual had entered the PA on 5 occasions (3 different days). Upon interview of the individual, the licensee learns he returned for an interview on once occasion. However, on the other occasions, came back to talk to other people in general. The Access Coordinator notifies the security supervisor, who determines the event as non-reportable.
- 10/11/96 The Security Manager learns of the situation and logs the event in the licensee's SEL.
- 10/16/96 The licensee determines the event to be 1 hour reportable. Call made to Region II (Stratton) and OPS Center.

PROBLEMS:

1. Procedure does not provide a form/checklist for termination.
2. Procedure denotes responsibility to the individual, their supervisor, and human resources to notify security upon termination. All three failed to do so.
3. No training on the procedure. Limited distribution of the procedure, however, the procedure is available to anyone.
3. Access Coordinator's failure to notify security and recognize the seriousness of the situation.
4. Security's failure to report the event. IR 96-16 (tampering event report) also identified a violation for failure to report.
5. The licensee's missed opportunity to investigate/correct the problem when CR-2041 was identified. This was a precursor to the event.

6. If the individual had not processed in at PSL, the problem may not have been identified, and the licensee would still not know an unauthorized individual had entered the PA.
7. Corporate QA had responsibility to ensure compliance with this procedure. No evidence that was ever initiated.
8. This problem is FPL wide. PTN also has identified individuals who had access after they were terminated. No other individuals who had access after termination entered either site.
9. Numerous severance packages and termination at FPL.
10. Security's inadequate investigation of the event in that, the two people identified by the individual as being visited on the days when the individual accessed the site were interviewed. That's all that was done as far as Security's investigation. Upon independent inspection, this inspector learned that the two individuals spent approximately 2 hours with the individual, 1.5 hours on 8/15 and 15 minutes on 8/7. According to access records, the employee was in the protected area as follows:

|         |               |                      |
|---------|---------------|----------------------|
| 8/7/96  | 12:02 - 12:45 | (43 minutes)         |
| 8/7/96  | 12:59 - 14:28 | (30 minutes)         |
| 8/7/96  | 14:37 - 17:15 | (2 hours 38 minutes) |
| 8/9/96  | 10:07 - 13:37 | (3 hours 30 minutes) |
| 8/15/96 | 12:47 - 17:37 | (4 hours 50 minutes) |

Approximately 10 hours inside the protected area are unaccounted for.

11. Individual had PA and VA access. Did not enter any VAs during the times noted above.

## REQUIREMENTS

### REPORTING

SP 6125, Reporting of Safeguards Events, Rev. 9, 4/20/95:

- 3.4 Definitions

Unauthorized person: Any unescorted person in the area to which the person is not authorized unescorted access.

- 8.2 The following safeguard events shall be reported within one (1) hour after receipt or recognition:

B. Any actual entry of an unauthorized person into the protected area or vital area.

### UNAUTHORIZED ACCESS

PSP Rev. 48, 2/23/96

- Definitions

Authorized persons: any individual who is properly badged for the level of access required.

- 3.2.3

Unauthorized personnel or material will be detected through access control procedures or hardware use at the protected area portals.

- 5.22

Only those individuals with an identified need for access and having appropriate authorization shall be granted unescorted vital area access.

- 13.4.4

AP 10509

- 3.4 Definitions

An administrative determination that a person requires access in the performance of his official duties and that the person is authorized to have access.

- 5.2 Department Heads and Supervisors are responsible for:

5. Notifying Security when unescorted access is no longer required of that there will be an absence of more than 30 days for any badged person.



- 5.6 Each person issued a picture badge/key card shall be responsible for:
  - 6. Notifying Security when unescorted access is no longer required of that there will be an absence of more than 30 days and for turning the badge in to Security immediately upon termination of unescorted access authorization.
- 5.7 The Plant Resource Control Supervisor is responsible for notifying the Security Department of personnel changes via the Personnel Change Report and the Plant Employee Roster. Interim notification may also be made by the Human Resources Department.
- 8.0 Instructions
  - 10. When an individual no longer requires unescorted access, he/she or department head or contractor/vendor shall notify the Badging Office immediately. The badged individual shall turn in the card key. For PSL, FPL employees, notification is also made through the Personnel Change Report showing terminations, additions, changes. In all cases, upon such notification, unescorted access is inactivated whether the badge is turned in immediately or not.

The NRC inspectors reviewed plant security records which listed all persons whose site access had been terminated during the period 1/1/96 - 10/31/96. Additionally, FP&L Human Resources personnel from Juno and the St. Lucie site were contacted for information regarding personnel related actions.

Those records indicated the following:

- 7/15/96 Subject was informed that his position was to be eliminated and is presented with termination package with an effective date of 9/16/96.
- 7/16/96 Access to St. Lucie site terminated by Security.
- 7/22/96 "Manager" requests that subject's access be reinstated to serve as Nuclear Services Administrator. Access is authorized.
- 9/09/96 Subject's work is complete. St. Lucie site access is again terminated.
- 9/16/96 Subject is removed from FP&L payroll.

The records indicated that at no time was the subject on site without an authorized access.

The inspector could find no requirement preventing the licensee from reinstating an individual's access after presenting the individual with a termination package. In this particular case, the subject's expertise was needed at the St. Lucie site after being presented with a termination package which required access to the facility.