

USNRC REGION II
ATLANTA, GEORGIA

83 JUN 1 P11:16



May 23, 1983
L-83-320

Mr. James P. O'Reilly
Regional Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta Street, Suite 3100
Atlanta, Georgia 30303

Dear Mr. O'Reilly:

Re: St. Lucie Unit 1
Docket No. 50-335
IE Inspection Report 83-05

Florida Power & Light Company has reviewed the subject inspection report and a response is attached.

There is no proprietary information in the report.

Very truly yours,

A handwritten signature in dark ink, appearing to read "Robert E. Uhrig", is written over the typed name.

Robert E. Uhrig
Vice President
Advanced Systems & Technology

REU/PLP/js

Attachment

cc: Harold F. Reis, Esquire

8307140401 830629
PDR ADOCK 05000335
Q PDR

ATTACHMENT

ST. LUCIE UNIT 1
DOCKET NO. 50-335
IE INSPECTION REPORT 83-05

Finding:

Technical Specification 6.8.1.b requires that written procedures shall be established, implemented and maintained for refueling operations. Operating Procedure No. 160023, Revision 11, Refueling Sequencing Guidelines, was written to "provide guidelines for sequencing the operations and maintenance procedures from Hot Standby Condition (Mode 3) to Refueling Condition (Mode 6) and return to Hot Standby Condition." Sign-off spaces (including critical Quality Control (QC) holds points) are provided for each step.

Contrary to the above, on March 9, 1983, the inspector found that no official copy had been designated and no signoffs had yet been made even though the plant was 20 steps into the procedure. One step was a QC hold point to assure containment cleanliness prior to detensioning the reactor vessel head-studs. The studs had been detensioned and the hold point was not signed.

Response:

1. FPL concurs with the finding.
2. The finding resulted from an oversight on the part of Control Room personnel to adequately document completion of evolutions in the appropriate procedure. Individual procedures being used were in fact being properly signed off; however, completion was not being indicated in the overall "sequencing document".
3. Upon notification by the NRC resident inspector, the discrepancy was immediately corrected by updating the sequencing document.
4. As corrective action to preclude recurrence of this type of event, all Operations personnel were reinstructed on the importance of the proper and timely use of procedures by means of a Night Order dated May 9, 1983.
5. Full compliance was achieved on May 9, 1983.