

Saint Lucie 1

1Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Barrier Integrity

G**Significance:** Dec 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Maintain Spray Additive Tank NaOH Concentration Within TS Limits

The inspector identified a non-cited violation of Technical Specification 3.6.2.2.a. for failure to maintain the Unit 1 spray additive tank NaOH concentration within the prescribed range of 28.5 to 30.5%.

This finding is greater than minor because if left uncorrected it could have resulted in a condition where an insufficient amount of NaOH existed to adequately buffer the pH of reactor coolant inside containment during design basis accidents. The finding affected the Barriers Cornerstone, and was determined to be of very low safety significance according to the SDP Phase 1 worksheet since it did not represent a degradation in the radiological barrier function of the containment.

Inspection Report# : [2003007\(pdf\)](#)

Emergency Preparedness

G**Significance:** Apr 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Meet 10 CFR 50.54(q) Change Requirements Which Resulted In A Decrease Of Emergency Plan Effectiveness

Green. A change made to the Emergency Action Limit (EAL) for Reactor Coolant System (RCS) leakage requiring an Unusual Event declaration resulted in a decrease in the effectiveness of the Emergency Plan.

A non-cited violation of 10 CFR 50.54(q) was identified by the NRC inspector. This finding is greater than minor because changing commitments in the Radiological Emergency Plan (REP) which decrease its effectiveness without prior approval potentially impacts the NRC's ability to perform its regulatory function, and potentially creates an ineffective response to a radiological emergency. The safety significance of the finding is very low because, although the Unusual Event declaration could be delayed as a result of the change made to the EAL, criteria for declaration of an Alert and subsequent response, remained unchanged.

Inspection Report# : [2003004\(pdf\)](#)

Occupational Radiation Safety

G**Significance:** Jun 28, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure Of A Designated Standby Rescue Person To Maintain Continuous Communication With Worker Provided With Supplied-Air Hood Respiratory Equipment (Section 2OS1.1)

Green. A self-revealing non-cited violation of 10 CFR 20.1703 (f) was identified for the failure of the designated standby rescue person to maintain continuous communication with a worker provided with supplied-air hood respiratory equipment during reactor head maintenance activities.

This finding is greater than minor because the failure to maintain continuous communication between the worker and the designated rescue person potentially could decrease timeliness in providing assistance to the worker whose air supply failed in this case, or for any other reason that the individual may have required relief from distress. The finding is of very low safety significance because an indirect communication channel was available between the affected worker and the standby rescue person and, following the loss of breathing air event, was used to request appropriate assistance in a timely manner (Section OS1.1).

Inspection Report# : [2003005\(pdf\)](#)

Public Radiation Safety

Physical Protection



Significance: G Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Search New Fuel Containers Prior To Entering The Protected Area (Section 1R20).

Green. A non-cited violation was identified for the licensee's failure to comply with Section 3.3.6 of the Physical Security Plan. On March 4, 2003, security personnel allowed a shipment of new fuel containers to enter the Protected Area (PA) without performing an adequate search.

This finding is greater than minor because allowing new fuel storage containers, with inadequate seals, to enter the PA without being searched could have adversely affected the licensee's ability to provide adequate assurance that the physical protection program can protect against the design basis threat of radiological sabotage. This finding was evaluated using the Interim Physical Protection Significance Determination Process and determined to be of very low safety significance. The finding was a vulnerability in the implementation of PA search requirements that did not involve a malevolent act, and there had not been two similar findings in four quarters. (Section 1R20)

Inspection Report# : [2003005\(pdf\)](#)

Miscellaneous

Significance: N/A Feb 27, 2004

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The inspectors determined that the licensee was generally effective in identifying problems and entering them into the Corrective Action Program. In general, the threshold for initiating Condition Reports (CRs) was low and employees were encouraged by management to initiate CRs.

The inspectors concluded that the Quality Assurance (QA) audits were comprehensive, were well conducted, and had identified numerous performance problems. For example, licensee Quality Assurance identified that not all self assessments or quarterly CR rollups scheduled for performance in 2003, were actually performed as required by plant procedures. Quality Assurance also identified that there has been a lack of emphasis on completing corrective actions as exemplified by an increasing backlog of overdue Plant Management Action Items (PMAIs). At the time of this inspection there was a backlog of 360 overdue PMAIs of varying importance. Additionally, the inspectors observed that a recent revision to procedure ADM-07.01, PMAI Corrective Action Tracking Program removed all time limits for closure of PMAIs.

The inspectors did not identify any reluctance by the plant staff to report safety concerns. The inspectors concluded that the employee concerns program, Speakout, was functioning well.

Inspection Report# : [2004007\(pdf\)](#)

Last modified : May 05, 2004