

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

FILE NUMBER

INCIDENT REPORT

TO: N.C. Moseley

FROM: Florida Power & Light Co.  
Miami, Florida  
A.D. Schmidt

DATE OF DOCUMENT

4-2-76

DATE RECEIVED

4-15-76

LETTER  
 ORIGINAL  
 COPY

NOTORIZED  
 UNCLASSIFIED

PROP

INPUT FORM

NUMBER OF COPIES RECEIVED

30

DESCRIPTION

Ltr. trans the following.....

ENCLOSURE

Reportable Occurrence # 76-1 Licensee Event Report on 3-3-76 Concerning the water level in the refueling cavity being below the top of the fuel transfer tube.....

(30 Cys. Received (No Original))

**ACKNOWLEDGED**

**DO NOT REMOVE**

PLANT NAME: St. Lucie # 1

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED SEND DIRECTLY TO KREGER/J. COLLINS

SAFETY

FOR ACTION/INFORMATION

ENVIRO

SAB 4-19-76

BRANCH CHIEF: Ziemann  
W/3 CYS FOR ACTION  
LIC. ASST: Diags  
W/ CYS  
ACRS 16CYS ~~HOLDING~~ SENT TO LA

INTERNAL DISTRIBUTION

REG FILE  
NRC PDR  
I & E (2)  
MIPC (3)  
SCHROEDER/IPPOLITO  
HOUSTON  
NOVAK/CHECK  
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CASE  
E. WILLIAMS  
HANAUER  
TEDESCO/MACCARY  
EISENHUT  
BAER  
SHAO  
VOLLMER/BUNCH  
KREGER/J. COLLINS

EXTERNAL DISTRIBUTION

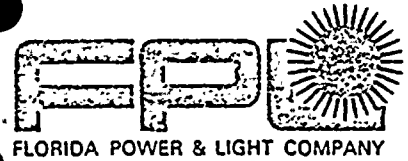
LPDR: Ft. Pierce, Florida  
TIC  
NSIC

CONTROL NUMBER

3821

FORM NO. 1

DOE



April 2, 1976  
PRN-LI-76-68

Regulatory

File Cya

Mr. Norman C. Moseley, Director, Region II  
Office of Inspection and Enforcement  
U. S. Nuclear Regulatory Commission  
230 Peachtree Street, N.W., Suite 818  
Atlanta, Georgia 30303



Dear Mr. Moseley:

REPORTABLE OCCURRENCE 335-76-1  
ST LUCIE UNIT 1  
DATE OF OCCURRENCE: MARCH 3, 1976  
BREACH OF CONTAINMENT INTEGRITY

The attached Licensee Event Report is being submitted in accordance with Technical Specification 6.9 to provide 30-day notification of the subject occurrence.

Very truly yours,

*for A. D. Schmidt*  
A. D. Schmidt  
Vice President  
Power Resources

MAS/jn

Attachment

cc: Jack R. Newman, Esquire  
Director, Office of Inspection and Enforcement (30)  
Director, Office of Management Information and  
Program Control (3)

3821





Event Description (continued)

incapable of automatic isolation. The immediate corrective action was to suspend core loading and restore the water level in the refueling cavity. Additional corrective action was to establish more frequent surveillance of the water level in the refueling cavity. This was the first occurrence of this type (335-76-1).

Cause Description (continued)

two probable causes of the water transfer. First, the refueling cavity water level may have been lowered during electrical checkout of the refueling canal sump pump motor. The sump pump was being tested concurrent with core loading and too much water may have been pumped from the refueling cavity to the Equipment and Chemical Drain System. Followup action was to place a clearance tag on the sump pump which prohibited use of the pump unless authorized by the Nuclear Plant Supervisor. Second, an incorrect valve lineup may have caused a gradual decrease in water level. However, since it was necessary to change the position of certain valves in order to restore the refueling cavity water level, it was not possible to verify that a valve lineup error had caused the occurrence. Followup action after restoring water level was to confirm that all valve lineups which could affect refueling cavity water level were correct for the operating condition then in effect.