Saint Lucie 2

Initiating Events

Mitigating Systems

Significance: G Sep 29, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Maintain Control of Fire Alarm Computer Design Features Required by the NRC Approved Fire Protection Program
Operating License DPR-67 (Unit 1), Condition 2.C(3), and Operating License NPF-16 (Unit 2), Condition 2.C(20), require the licensee to implement and maintain in effect all provisions of the approved fire protection program as described in the UFSAR and as approved by NRC safety evaluation reports. Section 3.5.2 of the UFSAR, Appendix 9.5A, Fire Protection Program, requires that fire protection systems shall be designed in accordance with NFPA 72A-1972 and NFPA 72D-1973 to ensure that detection system failures would be monitored and alarmed. Contrary to these system design requirements, several circuit boards were discovered missing from the Unit 1 and 2 Fire Alarm Computers. This condition, which has probably existed since shortly after original system installation, was subsequently dispositioned by the licensee's corrective action program as CRs 01-1845 and 2113. (Green)
Inspection Report# : 2001004*(pdf)*

Significance: G Jun 30, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Fire Detection Electrical Monitoring System Not in Accordance with Requirements
Operating License NPF-16 (Unit 2), Condition 2.C(20), specify that the licensee implement and maintain in effect all provisions of the approved fire protection program as described in the UFSAR and as approved by NRC SERs. NRC SER for Unit 2 dated October 1981 specifies that all fire detection systems used to actuate fire suppression systems will be Class A systems. Section 3.5.2.b of the Unit 2 UFSAR, Appendix 9.5A requires that fire protection systems shall be designed to ensure that any detector failure, single break, ground fault or wire to wire short will not prevent the transmission of an alarm, resulting in false operation, or cause a false indication of fire. The Unit 2 fire detection system had Class B style monitoring installed where Class A was required. With a Class B style electrical monitoring system, a single break or ground fault will result in a "trouble" condition for the initiating device circuits. This problem has existed since the original system installation and was discovered on February 14, 1998, and documented in the licensee's corrective action program as CR 98-0260. (Green)
Inspection Report# : 2001003*(pdf)*

Significance: G Jun 30, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Inadequate Testing of Sprinkler System

Operating License DPR-67 (Unit 1), Condition 2.C(3) and NPF-16 (Unit 2), Condition 2.C(20), specify that the licensee implement and maintain in effect all provisions of the approved fire protection program as described in the UFSAR and as approved by NRC SERs. Section 4.3.1.5 Automatic Water Suppression Systems of the UFSAR, Amendment 33, dated August 17, 1979, indicated that all station automatic water suppression systems conformed to NFPA 13 or 15. The testing and installed design for the water suppression sprinkler system was not consistent with NFPA 13 or NFPA 15. This condition has existed since the original system installation and was identified on February 20,1998, and documented in the licensee's corrective action program as CR(s) 98-0307, 98-0405, 98-0429. (Green)
Inspection Report# : 2001003*(pdf)*

Significance: G Dec 30, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
TS 6.2.2.a Minimum Shift Complement Not Maintained When NWE Relieved ANPS
Requirements of TS 6.2.2.a for minimum operating shift complement were not maintained when the NWE relieved the ANPS. The NWEs had not fulfilled proficiency watch requirements of 10CFR55.53 for SRO licenses (Section 4OA3)
Inspection Report# : 2000007*(pdf)*

Significance: G Sep 30, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform Trisodium Phosphate (TSP) Surveillance Testing According to TS 4.5.2.e.4
Green. A Non-Cited Violation of Technical Specifications was identified because the methodology used to conduct surveillance testing of the trisodium phosphate in containment was not as prescribed by Technical Specification 4.5.2.e.4. The issue was determined to be of very low safety significance based on the subsequent successful performance of a surveillance test. Additionally, the methodology used previously was not significantly different, from a technical perspective, than the method specified in the Technical Specifications. (Section 4OA3.1)
Inspection Report# : 2000006*(pdf)*

Barrier Integrity

Significance: G Mar 31, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure To Ensure Fulfillment of Control Room Emergency Cleanup System Safety Function
Green. A Non-Cited Violation of Technical Specifications (TS) 3.7.7 was identified addressing inadequate surveillance testing and operational controls for the Unit 2 control room emergency cleanup system. This finding was of very low safety significance because control room operator dose would not have exceeded 10CFR100 limits if a design basis event had occurred, and subsequent surveillance testing demonstrated that the system had been functionally capable of fulfilling its intended safety purpose. (Section 1R15.1)
Inspection Report# : 2000008*(pdf)*

Significance: G Mar 31, 2001
Identified By: NRC

Item Type: NCV NonCited Violation
Failure To Identify And Promptly Correct CRECS Issues
Green. A Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, Corrective Action, was identified for failing to promptly identify and correct a condition adverse to quality affecting the Unit 2 control room emergency cleanup system . This finding was of very low safety significance because the condition adverse to quality was of very low safety significance. Control room operator dose would not have exceeded 10CFR100 limits if a design basis event had occurred and the system had been functionally capable of fulfilling its intended safety purpose.
Inspection Report# : 2000008*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance: G Dec 30, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure of a Security Officer posted as Compensatory Measure for a Deactivated Alarm System to Maintain a Position to View the Zone of Detection
Green. The inspectors identified a non-cited violation of the St. Lucie Security Plan. A security officer posted at perimeter gate 04 was not in a position which allowed him to observe the areas for which he was providing compensatory measures. The finding was of very low safety significance because of the non-predictable basis of the single officer failure and there was no evidence that the vulnerability had been exploited, (Section 3PP3.2)
Inspection Report# : 2000007*(pdf)*

Miscellaneous

Significance: N/A Apr 25, 2002
Identified By: NRC
Item Type: FIN Finding
Identification and Resolution of Problems Based on the results of the inspection, no findings of significance were identified. The implementation of the corrective action program was acceptable.
Based on the results of the inspection, no findings of significance were identified. The implementation of the corrective action program was acceptable. There was an isolated maintenance effectiveness issue involving repairs to a failed

emergency diesel generator cooling system radiator. Overall, the licensee properly classified discrepant conditions and corrective actions were completed in a timely manner with respect to plant risk. The licensee's quality audits were effective in identifying deficiencies in the licensee programs. The inspectors did not observe a reluctance to report safety concerns.
Inspection Report# : 2002005*(pdf)*

Significance: N/A Feb 02, 2001
Identified By: NRC
Item Type: FIN Finding
Corrective Action Program
The inspectors determined that the licensee was effective at identifying problems and entering them into the corrective action program. Generally, problems entered into the program were adequately evaluated and appropriate corrective actions were identified. Formal root cause evaluations and corrective actions for significant issues were thorough and detailed. Corrective actions were generally implemented in a timely manner commensurate with their safety significance. However, the licensee's efforts to upgrade the emergency operating procedures to incorporate revisions and other changes to the Combustion Engineering emergency procedure guidelines have not been timely. This issue had also been recently identified by the licensee and actions were initiated to more aggressively address the procedure changes. Interviews and other information indicated that plant employees were not reluctant to report nuclear safety issues.
Inspection Report# : 2001002*(pdf)*

Last modified : August 29, 2002