Saint Lucie 1

Initiating Events

Mitigating Systems

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: Dec 31, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Radiation Protection Procedures for Access Controls to Radiologically Significant Areas
Green. The licensee failed to follow radiation protection procedures for access controls associated with radiologically significant areas. The failure to follow Radiation Work Permit (RWP) and procedural requirements resulted in workers inappropriately accessing high radiation area (HRA) locations not permitted by their RWP details and in workers entering an airborne radioactive material area without monitoring stay-times used for Derived Air Concentration-hour (DAC-hr.) tracking or revising RWPs. A non-cited violation (NCV) of Technical Specification (TS) Sections 6.11 and 6.12, with one NRC-identified and two self-revealing examples, was identified. Each of these examples is greater than minor in that the failure to follow procedures which resulted in workers inappropriately accessing HRAs and airborne areas was associated with the program and process attributes of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective to protect occupational workers from exposure to radiation. Each example is of very low safety significance because all individuals were monitored for exposures from external radiation fields and from internally deposited radionuclides, as appropriate; and no individuals exceeded either internal or external exposure limits. (Section 2OS1.1).
Inspection Report# : 2003010*(pdf)*

Significance: Dec 31, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Radiation Protection Procedures for Surveys of Radiologically Significant Areas
Green. The licensee failed to follow radiation protection procedures for conducting surveys of personnel. Specifically, the licensee failed to survey the work area directly through surveys or indirectly through extremity monitoring for two workers entering the Unit 1 (U1) reactor containment building (RCB) lower cavity and failed to conduct discrete radioactive particle (DRP) surveys at the required frequency for outage activities conducted in the U1 Refueling Pool, including incore instrumentation (ICI) change-out. An NCV of TS Section 6.11, with an NRC-identified and a self-revealing example, was identified. Each of these examples is greater than minor. Specifically, the failure to follow procedures for radiation surveys resulted in workers entering the RCB lower cavity without the knowledge of actual radiological conditions and decreased effectiveness of DRP monitoring during tasks conducted in the refueling pool, e.g., change-out. These examples are associated with radiation protection program and process attributes of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective. Each example is of very low safety significance based on retrospective reviews of the radiological conditions on the lower cavity floor and reactor head prior to decontamination and the dispersal of radioactive contamination due to hydrolasing activities. Further, exposure to radiation and radioactive material, including DRPs, was within regulatory limits for all occupational workers involved in the U1 End of Cycle 18 refueling outage (U1 EOC 18 RFO) activities. (Section 2OS1.1)
Inspection Report# : 2003010*(pdf)*

Significance: Dec 31, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Radiation Protection Procedures for Posting of Radiologically Significant Areas
Green. The licensee failed to follow radiation protection procedures for postings associated with radiologically significant areas which resulted in an improperly posted high radiation area at the dry storage warehouse and an airborne radioactivity area at the reactor containment building equipment hatch access. A self-revealing NCV of TS Sections 6.11 and 6.12, with two examples, was identified. Each of these examples is greater than minor in that the failure to follow procedures which decreased the effectiveness of radiological controls for workers entering HRAs and airborne radiation areas was associated with radiation protection program and process attributes of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective. Each example is of very low safety significance because any workers who may have entered the unposted airborne radiation and HRA conditions were required to wear appropriate monitoring devices within the areas, workers exiting the radiological control area (RCA) are screened for internally deposited radionuclides, and exposures resulting from both external radiation sources and from airborne radioactivity conditions were within regulatory limits for all occupational workers involved in the U1 EOC 18 RFO activities. (Section 2OS1.1)
Inspection Report# : 2003010*(pdf)*

Public Radiation Safety

Significance: Dec 31, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Radiation Protection Procedures for Surveys of Personnel
Green. The licensee failed to follow established procedures for personnel monitoring surveys which resulted in the release of radioactive material offsite. A self-revealing NCV of TS Section 6.11 was identified. The failure to follow procedures resulting in the inappropriate release of radioactive material offsite is associated with radiation protection program and process attributes of the Public Radiation Safety Cornerstone and affected the cornerstone objective to protect members of the public from exposure to radiation, and is therefore greater than minor. The finding is of very low safety significance because there have been less than five occurrences of material released outside the protected area in the past two-year period and it did not involve doses to a member of the public in excess of five millirem (mrem) Total Effective Dose Equivalent (TEDE). (Section 2OS3.2)
Inspection Report# : 2003010*(pdf)*

Significance: Dec 31, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Have Written Radiation Protection Procedures for Radiological Surveys of Potentially Contaminated Clothing Bulk-Released to the Public Domain
Green. The licensee failed to have adequate written procedures for radiological surveys of potentially contaminated material which resulted in the release of radioactive material offsite. A self-revealing NCV of TS Section 6.11 and 10 CFR 20.1501(a) was identified. The finding is greater than minor in that the inappropriate release of contaminated materials offsite is associated with radiation protection program and process attributes of the Public Radiation Safety Cornerstone and affected the cornerstone objective to protect members of the public from exposure to radiation. The finding is of very low safety significance because there have been less than five occurrences of material released outside the protected area in the past two-year period and it did not involve doses to a member of the public in excess of five mrem TEDE. (Section 2PS3.3)
Inspection Report# : 2003010*(pdf)*

Physical Protection

Significance: Sep 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide an Escort for a Visitor in Protected Area
Green. A non-cited violation was identified for the licensee's failure to comply with Section 4.5.3 of the Physical Security Plan. On August 14,

2002, security personnel, performing access control duties, permitted a visitor to enter the protected area, and subsequently proceed to the South Service Building (SSB), without an escort. This finding was evaluated using the Physical Protection Significance Determination Process and determined to be of very low safety significance. The finding was a vulnerability in access control that did not involve a malevolent act, and there had not been two similar findings in four quarters. (Section 3PP2)
Inspection Report# : 2002003*(pdf)*

Miscellaneous

Significance: Dec 31, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure To Maintain Control Of Overtime Limits During SL1-18
Inadequate management and supervisory awareness of the administrative requirements for controlling overtime resulted in multiple instances of plant personnel exceeding the overtime limits during the unit 1 outage without proper authorization and documentation. A non-cited violation of TS 6.2.2.f was identified by the NRC. This finding is greater than minor because if left uncorrected it could become a more significant safety concern due to excessive fatigue by personnel performing safety-related activities. The safety significance of the finding was very low because there were no specific performance deficiencies associated with the individuals during the time they exceeded the established overtime limits. (Section 1R20).
Inspection Report# : 2002004*(pdf)*

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. 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)*

Last modified : March 25, 2003