

Saint Lucie 2

1Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Mar 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Cables in Containment Fail to Meet 10 CFR 50, Appendix R, Criterion III.G.2 Requirements

Green. The inspectors identified a non-cited violation for the licensee's failure to comply with 10 CFR 50, Appendix R, Criterion III.G.2. This finding is related to a lack of spacial separation or barriers to protect cables in containment which could result in spurious opening of the pressurizer power operated relief valve (PORV) during a fire. This finding is greater than minor because it affected the mitigating systems cornerstone objective of equipment reliability, in that, spurious opening of the PORV during post-fire safe shutdown would adversely affect the ability to achieve and maintain the reactor in a hot shutdown condition. The finding is of very low safety significance because the initiating event likelihood was low, manual fire suppression capability remained unaffected and all mitigating systems except for the PORV and block valve were unaffected. (Section 40A5)

Inspection Report# : [2003002\(pdf\)](#)

Barrier Integrity

Significance:  Dec 31, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate Door Seal Resulted In Both Unit 2 Control Room Emergency Air Cleanup System Trains Inoperable For A Time Longer Than 24 Hours.

Inadequate door seal evaluation during maintenance activities resulted in both trains of Unit 2 control room emergency air cleanup system (CREACS) inoperable for a time longer than 24 hours. A self-revealing non-cited violation of Technical Specification 3.7.7 Action b was identified. This finding is greater than minor because it affected the barrier integrity cornerstone objective of providing reasonable assurance that physical design barriers provide protection from radionuclide releases caused by accidents or events. The finding is of very low safety significance because CREACS was able to maintain a positive pressure during the affected period and the control room envelope remained operable with respect to its design bases function of maintaining operator dose within general design criterion (GDC) 19. (Section 40A3.2).

Inspection Report# : [2002004\(pdf\)](#)

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: 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 : May 30, 2003