

Saint Lucie 1 4Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Accomplish Prescribed Procedure Steps Resulting in Starting the 1B LPSI Pump With its Suction Valve Closed

A self-revealing NCV of Technical Specification 6.8.1.b, "Refueling Operations," was identified when the licensee failed to properly implement system operating procedure NOP-03.05, "Placing the 1B SDC System in Operation" while attempting to restore reactor plant shutdown cooling (SDC) flow. As a result a low pressure safety injection (LPSI) pump was started with its suction valve closed which caused the pump to cavitate. This finding had human performance cross-cutting aspects in that an operator failed to comply with procedural requirements.

This finding is greater than minor because it is associated with the configuration control and human performance attributes of the Initiating Events cornerstone and adversely impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. In addition, if left uncorrected, this finding would result in a more significant safety concern. The inspectors evaluated the finding using Inspection Manual Chapter (IMC) 0609, Appendix G, Attachment 1, Checklist 3, "Pressurized Water Reactor (PWR) Refueling Operations with RCS Open and Refueling Cavity Level < 23 feet." The finding affected one train of decay heat removal (DHR) which was required to be operable; therefore, the finding did not screen out in Phase 1. Subsequently, the Region II SRA evaluated the finding using the IMC 609, Appendix G, Attachment 2, Phase 2 Significance Determination Process Template for PWR During Shutdown. This finding was a precursor finding that has the potential to cause a loss of the operating train of DHR. The Phase 2 SDP evaluation determined the finding to be of very low safety significance (Green) because the required operating SDC train was only briefly interrupted; the standby SDC train was promptly placed in service; and the affected train was quickly restored. The licensee took prompt action to enter the item into their corrective action program and implement interim corrective actions. The cause of the finding is related to the cross-cutting element of human performance. (Section 1R20)

Inspection Report# : [2005005\(pdf\)](#)**G****Significance:** Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to take timely and effective corrective actions to control hot work activities while being planned or performed to prevent recurrence

A NCV of TS 6.8.1.f, Fire Protection Program Implementation, was identified by the inspectors during a trend review of multiple small fires in the Unit 1 containment building during outage hot work (air arc gouging) activities. The inspectors determined that the licensee failed to take timely and effective corrective actions to control hot work activities. The licensee entered the issue into their CAP as Condition Report (CR) 2005-33661. This CR requires a comprehensive common cause analysis by a cross-functional team, which will examine the various fire protection issues identified, to determine whether or not a generic fire protection programmatic weakness is present.

This finding is greater than minor because it is associated with the protection against external factors attribute of the Initiating Events cornerstone and adversely impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. In addition, if left uncorrected, this finding would result in a more significant safety concern. The inspectors determined that the finding was associated with fire prevention and administrative controls and assigned a low degradation rating. As a result of the phase 1 screening, this finding was determined to be of very low safety significance. The cause of the finding is related to the cross-cutting element of problem identification and resolution, specifically involving incomplete corrective actions. (Section 4OA2)

Inspection Report# : [2005005\(pdf\)](#)

Mitigating Systems

G**Significance:** Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to maintain plant configuration control in accordance with administrative procedure ADM-17.18, Temporary System Alteration

The inspectors identified a non-cited violation (NCV) of TS 6.8.1.a and Regulatory Guide 1.33, for the licensee failing to implement administrative procedure ADM-17.18, Temporary System Alteration, Revision 6, when the control rod position circuit for control element assembly (CEA) 63 was altered to simulate the control rod position was at the upper electrical limit (UEL).

The finding was greater than minor because it is associated with the configuration control attribute of the mitigating systems cornerstone and affected the cornerstone objective of ensuring the reliability and capability of the rod control system. The finding was determined to be of very low safety significance in accordance with NRC Inspection Manual Chapter 0609, Appendix A, Attachment 1, the SDP Phase 1 screening worksheet because it did not represent an actual loss of the rod control system safety function and only affected one CEA in the entire rod control system.

Inspection Report# : [2005004\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Implement Required HP Controls for U1 Pressurizer Valve Work

A self-revealing NCV of Technical Specification (TS) 6.11 was identified for failure to implement adequate radiological controls for work near contaminated pressurizer components as required by Health Physics Procedure (HPP)-3, High Radiation Areas, Rev. 17A. On November 25, 2005, two individuals entered the Unit 1 (U1) pressurizer cubicle to perform a visual inspection of valve V1249 and subsequently became contaminated due to failure to follow Radiation Work Permit (RWP) requirements and inadequate Health Physics Technician (HPT) coverage.

This finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of exposure/contamination control and adversely affects the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operations. The failure to implement required RWP controls for high radiation area or highly contaminated area work activities could result in unintended exposures. The finding was determined to be of very low safety significance because the 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. The finding involved the cross-cutting aspect of Human Performance because the contamination events were a direct result of worker and HPT failures to implement required radiological controls. The licensee entered this finding in its corrective action program (CAP) as CR 2005-32859. (Section 2OS1).

Inspection Report# : [2005005\(pdf\)](#)

Public Radiation Safety

Significance:  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Appropriate DOT Type A Package Closure Requirements

The inspectors identified a NCV of 10 CFR 71.5 for failure to follow Department of Transportation (DOT) regulations for proper closure of Type A shipping packages. Specifically, for Type A packages containing in-core instrument cutting equipment shipped on October 3, 2003 and February 17, 2005, the licensee failed to prepare the package closures in accordance with the container vendor specifications as required by DOT 49 CFR 173.475 (e).

The finding was more than minor because it is associated with the Public Radiation Safety Cornerstone program and process attribute involving

transportation procedures. The cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive material released into the public domain was affected because the identified issue involved shipments of radioactive material that were contrary to NRC and DOT regulations. The finding is of very low safety significance (Green) because it did not involve a radiation limit being exceeded or a package being breached. This finding also involved the cross-cutting aspect of problem identification and resolution regarding implementation of Operating Experience (OE). Although the licensee had reviewed OE 19531 associated with lid bolting torque for a Type A package they did not enter this OE into their CAP process and implement actions to prevent similar occurrences. After inspector identification of the issue, the licensee entered this finding into the CAP as CR 2005-25727 (Section 2PS2).

Inspection Report# : [2005005\(pdf\)](#)

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Jan 14, 2005

Identified By: NRC

Item Type: FIN Finding

Special Inspection's Findings and Observations Related with Breaker Failures

- After two safety-related 4160 volt circuit breakers failed to close, the licensee developed and performed sufficient tests to verify the ability of the remaining safety-related 4160 volt circuit breakers to operate.
- While the initial operability tests ensured that a breaker would cycle once, the licensee did not take into consideration breakers that must operate multiple times in performing various design functions. As a result, for any breaker cycled after passing an initial voltage verification test, but before operability was confirmed by a smooth operation check of the spring charging motor limit switch bracket, the licensee did not have reasonable assurance that the breaker would perform its safety function until a second successful voltage verification test was completed.
- The licensee's root cause evaluation was sufficient to identify the cause of the breaker failures associated with the 1A and 1C Component Cooling Water Pump Breakers. However, it did not examine the following potential programmatic or organizational causes of the breaker failures: inadequate receipt inspection for the 1A Component Cooling Water Pump Breaker evidenced by the failure to identify the bent limit switch bracket; failure to refurbish the 1C Component Cooling Water Pump Breaker within the time frame identified in the maintenance program, or to identify the technical basis for extending the refurbishment cycle by 25%; and failure of the preventive maintenance procedure to identify the degraded performance of the 1C Component Cooling Water Pump Breaker.
- The licensee did not fully implement industry related operating experience in two areas; post-refurbishment receipt inspection of the Westinghouse DHP 4160 volt breakers and effects of hardened grease on 4160 volt breaker operation.

Inspection Report# : [2004011\(pdf\)](#)

Last modified : March 03, 2006