Saint Lucie 1
3Q/2008 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedure Fails to Limit the likelihood of Heavy Load Drop Accident in Containment
The inspectors identified a NCV of 10 CFR 50, Appendix B, Criterion V, AInstructions, Procedures, and Drawings,@ for the licensee failing to have in place adequate heavy load handling procedures that would control and limit the likelihood of a heavy load drop in the containment building. The licensee entered the finding in their corrective action program for resolution as condition report 2007-14366.

The finding is greater than minor in accordance with IMC 0612, Power Reactor Inspection Reports,@Appendix B, Issue Screening.@ Specifically, the finding is related to the Initiating Events cornerstone attribute of equipment performance in that the subject reactor vessel maintenance procedures did not control or limit the likelihood of a load drop event in containment that could challenge plant stability while shutdown. This finding is not suitable for an SDP evaluation but has been reviewed by NRC management and was determined to be of very low safety significance (Green). The finding was not greater than Green because no actual load drop accident had taken place. No cross-cutting aspect associated with this finding was identified. (Section 4OA5)

Inspection Report# : 2008003 *(pdf)*

Significance: G Mar 31, 2007
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Implement Atmospheric Dump Valve Maintenance Procedure
A self-revealing finding was identified following an event when Unit 1 inadvertently entered Operational Mode 3 (Hot Standby) due to a failure of the 1A air operated atmospheric dump valve (HCV-08-2A) actuator diaphragm and subsequent plant heat up. It was determined that inadequate maintenance instructions resulted in damage to the actuator diaphragm. The licensee documented this issue in condition report (CR) 05-28232 with corrective actions to develop a written maintenance procedure to perform future actuator maintenance in accordance with component technical manual requirements.

This finding is greater than minor because it affected the equipment reliability attribute of the Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions while the plant is shutdown. The finding was determined to be of very low safety significance because it only affected the Initiating Events Cornerstone and does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. A contributing cause of the finding is related to the cross cutting area of Human Performance specifically Resources, because the licensee did not have a complete and accurate work package to perform this maintenance activity. (Section 4OA3.1)
Inspection Report# : 2007002 *(pdf)*

Mitigating Systems

Significance: G Sep 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Demonstrate Ten Minute Station Blackout Requirement
The inspectors identified a non-cited violation (NCV) of 10 CFR 50.63 for the licensee's non-compliance with the station blackout rule since 1993. The licensee failed to demonstrate that electrical power for Unit 1 could be provided within ten minutes of the onset of a station blackout (SBO) event and subsequently failed to perform a coping analysis when the ten minutes was not demonstrated. The licensee initiated condition report 2007-28746 with an action to perform a coping analysis in lieu of demonstrating that the ten minute commitment could be met. The coping analysis will be reviewed by the NRC (Office of Nuclear Reactor Regulation).

This finding is more than minor because it is associated with the equipment performance attribute and affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to preclude undesirable consequences during a station blackout. The inspectors did not identify a cross-cutting aspect for this finding. (Section 4OA5.1)

Inspection Report# : 2008004 *(pdf)*

Significance: G Sep 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Monitor the Station Blackout Cross-tie Cable
The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50.65(a)(1) for the licensee's failure to monitor the SBO cross-tie cable for Units 1 and 2 against license established goals. The cable has not been tested or energized since 1993. The licensee initiated condition report 2007-36986 for the development of a monitoring program for the cross-tie cable.

This finding is more than minor because it is associated with the design control attribute and affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to preclude undesirable consequences during a station blackout. The inspectors did not identify a cross-cutting aspect for this finding. (Section 4OA5.2)

Inspection Report# : 2008004 *(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: G Dec 31, 2007
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to follow procedures for the 2B Purification Ion Exchange system resin change-out activities
A self-revealing non-cited violation (NCV) of Technical Specification (TS) 6.8.1(a) for failure to follow procedural guidance established for radioactive resin replacement activities was identified. Specifically, on November 13, 2007, Operations personnel failed to follow details in Procedure 2-0520020, Appendix E necessary to ensure depressurization of the 2B Purification Ion Exchange system during conduct of a volumetric test associated with resin replacement activities. The failure to follow the established guidance resulted in the unanticipated and uncontrolled release of radioactive materials from the system and the subsequent contamination of personnel and the surrounding clean areas. The licensee entered aspects of this finding into their Corrective Action Program (CAP) as Condition Report (CR) Numbers 2007-37764, 2007-37632 and 2007-37618.

This finding was determined to be more than minor because the failure to follow established operations procedures is associated with the Occupational Radiation Safety cornerstone attributes of program and controls, and affected the cornerstone objective to protect occupational workers from unplanned and unintended exposure to radiation. The event is of very low safety significance based on the resulting exposures being within regulatory limits for all workers involved in the event and its cleanup. This finding involved the cross-cutting area of human performance and the aspect of work practices ((IMC 305, H.4.b)
Inspection Report# : 2007005 *(pdf)*

Public Radiation Safety

Significance: G Dec 31, 2007
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Appropriate DOT Type A Package Closure Requirements
The inspectors identified a Green NRC-identified NCV of 10 CFR 71.5 for failure to implement package design specifications for the proper

closure of Type A shipping packages as required by Department of Transportation (DOT) regulations. Specifically, for Type A packages containing Unit 1 Spent Resin Tank resin (shipment #06-27) shipped on April 30, 2006, and Unit 2 resin (shipment #06-32) shipped on April 14, 2006, the licensee failed to close the packages in accordance with vendor specifications as required by 49 CFR 173.22. The licensee entered the finding into their CAP as CR 2007-35026.

The licensee's failure to comply with 10 CFR 71.5 which requires compliance with 49 CFR Part 173 for DOT Type A package vendor engineering analysis specifications, instructions and procedures, was a performance deficiency. The finding was more than minor because it was associated with the public radiation cornerstone program and transportation program attribute and it affected the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive material released into the public domain. The issue was reviewed using the Public Radiation Safety Significance Determination Process and was determined to be of very low safety significance (Green) because it did not involve a radiation limit being exceeded nor packaging being breached. This finding involved the cross-cutting area of human performance and the aspect of work practices (IMC 305, H.4.b) for failure to follow procedures. (Section 2PS2)

Inspection Report# : 2007005 *(pdf)*

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Aug 25, 2006
Identified By: NRC
Item Type: FIN Finding
Identification and Resolution of Problems
The inspectors identified that the licensee was effective at identifying problems and entering them into the corrective action program. The licensee's effectiveness at problem identification
was evidenced by the relatively few deficiencies identified by external organizations
(including the NRC) that had not been previously identified by the licensee, during the
review period. The licensee effectively used risk in prioritizing the extent to which individual
problems would be evaluated and in establishing schedules for implementing corrective
actions. Corrective actions, when specified, were generally implemented in a timely
manner. Operating experience usage was also found to be effective. Self assessment results adequately identified problems. The inspectors identified a number of weaknesses that are detailed in the report in various aspects within the corrective action process.

On the basis of the samples selected for review, the inspectors concluded that, 1) in general problems were properly identified, evaluated, and corrected within your problem identification and resolution program, 2) the processes and procedures of your corrective action program were generally effective; thresholds for identifying issues were appropriately low, and in most cases, corrective actions were adequate to address conditions adverse to quality, and 3) on the basis of interviews conducted during this inspection, workers at the site felt free to input safety findings into the corrective action program.

Inspection Report# : 2006008 *(pdf)*

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 : November 26, 2008