

Saint Lucie 2

3Q/2005 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to adequately identify and report conditions potentially adverse to plant safety involving the 1C ICW pump discharge isolation valve

The inspectors identified a Non-Cited violation of 10 CFR 50, Appendix B Criterion XVI, Corrective Action, for the licensee's failure to enter a condition adverse to quality in the corrective action program and implement adequate corrective actions. Valve SB21206, 1C ICW Pump Discharge Isolation Valve was caution tagged as being unable to be closed, yet the licensee had not implemented appropriate compensatory measures to ensure that the 1C ICW pump could be started, if required, in accordance with station procedure 1-0640030, Off-Normal Operating Procedure, Intake Cooling Water System.

This NRC-identified finding was greater than minor because it is associated with the configuration control attribute of the initiating events cornerstone and affected the cornerstone objective of ensuring the reliability and capability of the ICW system. The inability to start the standby ICW pump in accordance with the off-normal procedure could have resulted in an emergent power reduction, had one of the two normally running ICW pumps tripped, based upon the insufficient heat removal capability of the remaining pump. During such an event, plant systems and components could have been challenged. The finding was determined to be of very low safety significance (Green) in accordance with NRC Inspection Manual Chapter 0609, Appendix A, Attachment 1, Significance Determination Process (SDP), Phase 1 screening worksheet because the ICW system could still perform its safety function, but was degraded. (Section 1R04)

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

Significance:  Dec 31, 2004

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Improper Implementation of Emergency Operating Procedure Following a Manual Reactor Trip

A self-revealing non-cited violation (NCV) was identified for failing to properly implement emergency operating procedure 2-EOP-99, Appendix X, Secondary Post Trip Actions, as prescribed by TS 6.8.1.a and Regulatory Guide 1.33. More specifically, a licensed reactor operator did not ensure the main feedwater regulating valve block valves were in the closed position following the reactor trip on December 25, which then directly contributed to the cause of another manual reactor trip on December 27.

The finding is greater than minor because it involved the human performance attribute of the Initiating Events Cornerstone and its objective, in that failure to follow and implement a required emergency operating procedure step directly contributed to a subsequent plant transient that resulted in a manual reactor trip. The finding is of very low safety significance because, although it caused a manual reactor trip, it did not increase the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to a combination of a reactor trip and loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flood. This finding directly involved cross cutting aspects of human performance. (Section 1R14)

Inspection Report# : [2004006\(pdf\)](#)

Mitigating Systems

Barrier Integrity

Significance:  Jun 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 of Technical Specification 6.8.1.a for failing to maintain configuration control of the unit 2 control room emergency ventilation system (CREVS) fan room structure in accordance with administrative procedure ADM-17.18, Temporary System Alteration, Revision 6.

The finding is greater than minor because it is associated with the plant modification design control attribute of the reactor safety barrier integrity cornerstone and affected the cornerstone objective of ensuring the reliability and capability of the control room emergency ventilation system. The finding was 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 only represented a degradation of the radiological barrier function provided for the control room. Until the issue could be permanently resolved, the licensee initiated a clearance order to control the system alterations. (Section 1R23)

Inspection Report# : [2005003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Significance: SL-IV Mar 31, 2005

Identified By: NRC

Item Type: VIO Violation

Failure to Comply with Requirements Established for the Conduct of Maintenance

On January 31, 2005, NRC issued a letter with Notice of Violation involving a failure to comply with the requirements established for the conduct of maintenance. Specifically, on May 26, 2003, megger testing was performed on the Unit 1 Control Element Assembly System without obtaining authorization from the Nuclear Plant Supervisor following an appropriate briefing and without obtaining the required clearance. The significance of the violation was assessed in accordance with Section IV of the NRC's Enforcement Policy and was identified as a Severity Level IV Violation. This violation is being tracked as VIO 05000335/2005002-001, Failure to Comply with the Requirements Established for the Conduct of Maintenance. The ADAMS accession number for the January 31, 2005 letter is ML0503020379.

Inspection Report# : [2005002\(pdf\)](#)

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

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 30, 2005