

NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL

FILE NUMBER

INCIDENT REPORT

TO: N.C. Moseley

FROM: Florida Power & Light Co.
Miami, Florida
A.D. Schmidt

DATE OF DOCUMENT

4-2-76

DATE RECEIVED

4-15-76

☐ LETTER
☐ ORIGINAL
☒ COPY☐ NOTORIZED
☒ UNCLASSIFIED

PROP

INPUT FORM

NUMBER OF COPIES RECEIVED

30

DESCRIPTION

Ltr. trans the following.....

ENCLOSURE

Reportable Occurrence # 76-1 Licensee Event
Report on 3-3-76 Concerning the water level
in the refueling cavity being below the top
of the fuel transfer tube.....

(30 Cys. Received (No Original)

ACKNOWLEDGED

DO NOT REMOVE

PLANT NAME: St. Lucie # 1

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED
SEND DIRECTLY TO KREGER/J. COLLINS

SAFETY

FOR ACTION/INFORMATION

ENVIRO

SAB 4-19-76

BRANCH CHIEF:

Ziemann

W/3 CYS FOR ACTION

LIC. ASST:

Diags

W/ CYS

ACRS 16CYS HOLDING/SENT TO LA

INTERNAL DISTRIBUTION

REG FILE

NRC PDR

I & E (2)

MIPC (3)

SCHROEDER/IPPOLITO

HOUSTON

NOVAK/CHECK

GRIMES/SCHWENCER

CASE

E. WILLIAMS

HANAUER

TEDESCO/MACCARY

EISENHUT

BAER

SHAO

VOLLMER/BUNCH

KREGER/J. COLLINS

EXTERNAL DISTRIBUTION

LPDR: Ft. Pierce, Florida

TIC

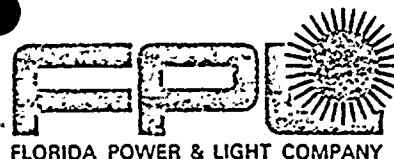
NSIC

CONTROL NUMBER

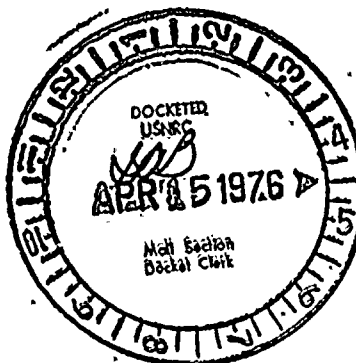
3821

FOR NO. 10

DOE



April 2, 1976
PRN-LI-76-68



Regulatory

File Cyd

Mr. Norman C. Moseley, Director, Region II
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
230 Peachtree Street, N.W., Suite 818
Atlanta, Georgia 30303

Dear Mr. Moseley:



REPORTABLE OCCURRENCE 335-76-1
ST LUCIE UNIT 1
DATE OF OCCURRENCE: MARCH 3, 1976
BREACH OF CONTAINMENT INTEGRITY

The attached Licensee Event Report is being submitted in accordance with Technical Specification 6.9 to provide 30-day notification of the subject occurrence.

Very truly yours,

A. D. Schmidt
for
A. D. Schmidt
Vice President
Power Resources

MAS/jn

Attachment

cc: Jack R. Newman, Esquire
Director, Office of Inspection and Enforcement (30)
Director, Office of Management Information and
Program Control (3)

3821



[PLEASE PRINT ALL REQUIRED INFORMATION]

GPO 881-667⁴

Event Description (continued)

incapable of automatic isolation. The immediate corrective action was to suspend core loading and restore the water level in the refueling cavity. Additional corrective action was to establish more frequent surveillance of the water level in the refueling cavity. This was the first occurrence of this type (335-76-1).

Cause Description (continued)

two probable causes of the water transfer. First, the refueling cavity water level may have been lowered during electrical checkout of the refueling canal sump pump motor. The sump pump was being tested concurrent with core loading and too much water may have been pumped from the refueling cavity to the Equipment and Chemical Drain System. Followup action was to place a clearance tag on the sump pump which prohibited use of the pump unless authorized by the Nuclear Plant Supervisor. Second, an incorrect valve lineup may have caused a gradual decrease in water level. However, since it was necessary to change the position of certain valves in order to restore the refueling cavity water level, it was not possible to verify that a valve lineup error had caused the occurrence. Followup action after restoring water level was to confirm that all valve lineups which could affect refueling cavity water level were correct for the operating condition then in effect.