ATTACHMENT B

TRIP REPORT

MEMORANDUM FOR: Deputy Regional Administrator

FROM: John P. JAUDON

SUBJECT: REPORT ON TRIP TO St. Lucie

DATE(S) OF VISIT: Jan 5-6, 1994

PURPOSE OF VISIT: Pre-SALP

INSPECTOR(S) OBSERVED: M. Miller, RI

SENIOR LICENSEE PERSON CONTACTED: D. SAGAR, Site VP

STRENGTHS OR WEAKNESSES NOTED WITH PLANT:

In an effort to reduce costs, Licensee is using engineering to solve reliability problems. I believe that this will have positive safety returns

OTHER COMMENTS:

Number of square feet of contamined area seemed very low. Licensee rep said total was 1450 ft^2.

J Jaudon 1/6/94

Signature / Date

cc: Regional Administrator
Technical Division Directors
Cognizant Senior Resident Inspector
Cognizant DRP Section Chief
Cognizant DRP Branch Chief

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ATTACHMENT C

REGULATORY IMPACT REPORTING FORM

DATE: 1/6/94

ORIGINATOR(NAME/ORG) John P. Jaudon, Dep. Dir, DRS, RII

LICENSEE FPL St Lucie

(NAME/TITLE) D. Sagar, Site Vice President

FAVORABLE FEEDBACK Licensee thought that resident and region based inspectors brought up issues in professional manner

UNFAVORABLE FEEDBACK (ISSUE OR PROBLEM) None expressed by Licensee

COMMENTS

RECOMMENDATIONS/RESOLUTION

cc: Chief, MOAS/ILPB, NRR
Cognizant Senior Resident Inspector
Cognizant DRP Section Chief
Cognizant DRP Branch Chief
Technical Division Directors
Deputy Regional Administrator
Regional Administrator

SLBRIEF.494

April 4, 1994

ST LUCIE

Recent Significant Events/ Findings

Date	Cause	Identified	Event/Finding
11/2/93	Operating procedures	Licensee	Unit 1 manual trip - abnormal turbine cooling water lineup at reduced power
1/1/94	-	-	SALP period ended
1/9/94	Equipment failure	licensee	Manual trip - feed pump control circuit failure
2/8/94	-	-	TPPR Conducted
2/17/94	Operator error	Licensee	Mispositioned valve discovered. Aux. pressurizer spray isolation valve had been locked closed (vice open) since 3/27/93.
3/16/94	Equipment failure	Licensee	A pressurizer instrument nozzle that had been repaired a year ago was found leaking. Failure a year ago was in Inconel 600 nozzle. The repair used an Inconel 690 nozzle and Inconel 182 shielded metal arc weld material. The repair was inspected by NRC, with 1 VIO for incorrect weld rod size. Current failure attributed to PWSCC of Inconel 182 shielded metal arc weld material. A new mod (re-using the Inconel 690 nozzles and an external Inconel 690 weld) is being inspected by NRC (Crowley/Coley). [CHANGED]
3/16/94	Engineering error	Licensee	Regional inspector has two potential violations: 1) inadequate corrective action for an 11/2/92 water hammer event, resulting in operating with two PORV tailpipe snubbers inoperable. 2) Failure to write nonconformance reports for the inoperable snubbers. IR not yet issued.
3/28/94	Maintenance error	Licensee	Auto reactor trip. Maintenance foreman opened breaker - on wrong unit and not authorized to operate breaker.

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3/29/94	Equipment failure	Licensee	Licensee discovered body-to-bonnet leak on non-isolable ten-inch shutdown cooling isolation valve. Leak rate about two drops/second (TS-allowable). Licensee installed exterior clamp and leak repair compound on valve.
4/2/94	Equipment failure	Licensee	Startup transformer output breaker fails to open.
4/3/94	Personnel Error (Lack of suficient depth in review of procedure change) [CHANGED]	Licensee	Reactor trip from 19% power while deenergizing the 4160 Volt non-vital bus to allow safe removal of the failed SU Tx output breaker for maintenance. The isolation placed the A emergency bus on the EDG, which was running at a different frequency from the grid. The paralleled CEA MG sets, now with different frequency drivers, developed circulating currents and several trippped circuit breakers. A partial reactor trip tripped the turbine, which tripped the reactor. [CHANGED]
4/3/94	Installed equipment error	Licensee	During testing for Unit 2 modifications the licensee discovered that the 4160 V [AB Bus] swing bus components [C ICW Pump and C CCW Pump] would not strip from the bus upon undervoltage if the bus were aligned to the B bus. A missing jumper wire in the switchgear was the proximate cause. This is being prepared for enforcement panel discussion. [CHANGED]

March inspector Tom Johnson failure to follow refueling bridge operating procedure resulted in trying to pick up two fuel bundles at a time.

March Inspector Elrod Failure to install proper connection washers on 2A safety battery - Maintenance supervisor error.

NRC CONCLUSION: The mispositioned valve and water hammer occurred over a year ago. None of the above personnel errors are similar. These events and findings may be precursors to declining performance. Further very close inspection and assessment is required.