



Florida Power & Light Company, 6501 S. Ocean Drive, Jensen Beach, FL 34957

August 3, 2007

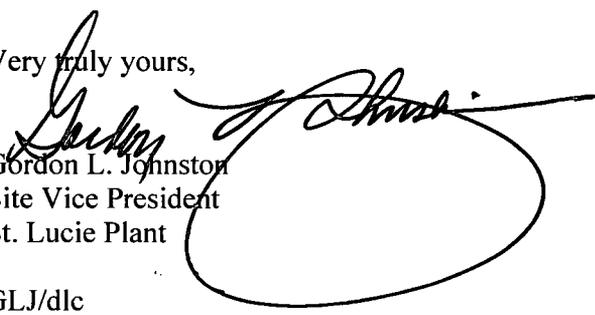
L-2007-120
10 CFR 50.73

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Re: St. Lucie Unit 1
Docket No. 50-335
Reportable Event: 2007-001-00
Date of Event: June 6, 2007
Mispositioned Containment Isolation Valves

The attached Licensee Event Report 2007-001-00 is being submitted pursuant to the requirements of 10 CFR 50.73 to provide notification of the subject event.

Very truly yours,


Gordon L. Johnston
Site Vice President
St. Lucie Plant

GLJ/dlc

Attachment

IE22

MRR

LICENSEE EVENT REPORT (LER)

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME St. Lucie Unit 1	2. DOCKET NUMBER 05000335	3. PAGE 1 OF 3
---	-------------------------------------	--------------------------

4. TITLE
Mispositioned Service Air Containment Isolation Valves

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV. NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
06	06	2007	2007	- 001 -	00	08	03	2007	FACILITY NAME	DOCKET NUMBER
									FACILITY NAME	DOCKET NUMBER

9. OPERATING MODE 1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: (Check all that apply)									
10. POWER LEVEL 100%	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input checked="" type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)						
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)						
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER							
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A							

12. LICENSEE CONTACT FOR THIS LER

NAME Donald L. Cecchett - Licensing Engineer	TELEPHONE NUMBER (Include Area Code) 772-467-7155
--	---

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
A	LF	PEN	N/A	NO					

14. SUPPLEMENTAL REPORT EXPECTED <input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE MONTH: - DAY: - YEAR: -
--	--

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On June 6, 2007, St. Lucie Unit 1 was in Mode 1 at 100 percent reactor power and while performing a surveillance to verify position of administratively locked valves for the containment and shield building integrity, two containment isolation valves, (CIVs), service air header to containment isolation (non-safety class system) were found locked open, versus the required locked closed position. The valves are required to be locked closed prior to entering Mode 4 in accordance with Technical Specifications 3.6.1 and plant procedures to ensure containment vessel integrity. The valves were restored to the locked closed position upon discovery. It was estimated the valves were left open for approximately 3 weeks from the time when Unit 1 entered into Mode 4 until time of discovery.

The apparent cause, along with contributing causes, was determined to be human error in which implementation of existing configuration control processes were incorrectly implemented by the Clearance Center Senior Reactor Operator (SRO). Corrective actions included re-performance of the procedure, creation and issuance of an Operations Event Report 07-008, and immediate standdown with all personnel.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
St. Lucie Unit 1	05000335	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	Page 2 of 3
		2007	- 001	- 00	

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

Description of the Event

On June 6, 2007, St. Lucie Unit 1 was in Mode 1 at 100 percent reactor power. While performing a surveillance to verify position of administratively locked valves [v] for the containment and shield building integrity, two containment isolation valves (CIVs) V18794 and V18796 (service air header to containment isolation)[PEN] were found locked open versus the required locked closed position. The valves are opened to provide service air to the containment during Mode 5 and 6 conditions through a containment penetration. The valves are required to be locked closed prior to entering Mode 4 in accordance with Technical Specifications 3.6.1 and plant procedures, and verified locked closed once every 31 days in accordance with administrative procedures.

Unit 1 exited Mode 5 and entered Mode 4 on 5/20/07 following a refueling outage. Prior to entering Mode 4 the valves were re-opened (previously closed) to support ongoing containment activities. Although, there are sufficient station processes and procedures in place to control components that are aligned outside of their normal position (e.g., valve deviation log, open penetration log, or equipment clearance orders), the Clearance Center SRO did not establish configuration control via these station procedures. In addition, during subsequent communications on the valve opening with the Control Room, the Clearance Center SRO did not clearly communicate that the now "open" penetration required tracking and documentation in the Open Penetration Log Data Sheet by the Control Room. This miscommunication resulted in the Control Room not logging it as an "open" penetration. These human performance errors and incorrect use of the configuration control process ultimately lead to the open position of the valves being missed by both the Control Room and the Clearance Center SRO when entering Mode 4.

Cause of the Event

The apparent cause, along with contributing causes, was determined to be human error in which implementation of existing configuration control processes were incorrectly implemented by the Clearance Center SRO. Contributing causes included inadequate communication, perceived schedule pressure, distractions, and less than adequate guidance in the configuration control procedures.

Analysis of the Event

In accordance with NUREG-1022, "Event Reporting Guidelines 10 CFR 50.72 and 50.73," Revision 2, this event is reportable under 10 CFR 50.73(a)(2)(ii)(A) as, a principal safety barrier being seriously degraded as well as 10 CFR 50.73(a)(2)(i)(B) as a condition or operation prohibited by the Technical Specifications.

Analysis of Safety Significance

Since the passage of service air into the containment is not needed or required for core damage mitigation, the CIVs are generally not included in the PSA model(s) used for estimating Core Damage Frequency (CDF). Inoperable CIVs (i.e. in the open position) for this penetration will not have an impact on CDF or Incremental Conditional Core Damage Probability (ICCDP).

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
St. Lucie Unit 1	05000335	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	Page 3 of 3
		2007	- 001	- 00	

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

The calculated Incremental Large Early Release Probabilities (ICLERPs) for both seismic and non-seismic event initiators indicate that the level of risk associated with large early releases due to CIVs V18794 and V18796 left in open position for 3 weeks (or 504 hours) is significantly below the acceptance criterion value of 5.0E8, and thus, based on Reg. Guides 1.177 and 1.174 the associated risk impact is considered small.

Corrective Actions

The proposed corrective actions and supporting actions listed below are entered into the site corrective action program. Any changes to the proposed actions will be managed under the commitment management change program.

The following actions will be tracked within the St. Lucie Corrective Action Program:

1. Appendix E of AP 1-0010123 "Containment and Shield Building Integrity Valve List" that was being used for the configuration control was re-performed.
2. Operations Department "Standdown" with all personnel was held to discuss the event and the Operations expectations regarding configuration control.
3. The Clearance Center SRO that involved in this event has been counseled.
4. Operations Event Report 07-008 on this issue was issued and reviewed by all operating crews.

Similar Events

A search of the PSL's Corrective Action database over the past two years was performed. The search included the event for program/process issues and events for configuration management issues. Thirty-four condition reports were found that addressed configuration management. A review of these condition reports did not reveal a similar event. No other condition reports were identified related to the above search topics.

Failed Components

None