



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

April 20, 2009

L-2009-087
10CFR 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: 2009-001
Date of Event: February 19, 2009

Unit 1 Verbatim Technical Specification Surveillance Testing

The attached Licensee Event Report 2009-001 is being submitted pursuant to the requirements of 10 CFR 50.73 to provide notification of the subject event.

Respectfully,

Christopher R. Costanzo for SVP
Gordon L. Johnston
Site Vice President
St. Lucie Plant

GLJ/dlc

Attachment

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 4
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4. TITLE Unit 1 Verbatim Technical Specification Surveillance Testing
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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
02	19	2009	2009	- 001		04	20	2009	FACILITY NAME	DOCKET NUMBER

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

12. LICENSEE CONTACT FOR THIS LER

NAME Donald L. Cecchetti - Licensing Engineer	TELEPHONE NUMBER (Include Area Code) 772-467-7155
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
X	DE	F	P	NO					

14. SUPPLEMENTAL REPORT EXPECTED

☐ YES (If yes, complete 15. EXPECTED SUBMISSION DATE) ☒ NO

15. EXPECTED SUBMISSION DATE

MONTH	DAY	YEAR

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

On February 19, 2009, St. Lucie Unit 1 was operating in Mode 1 at 100% power when it was determined that the completed surveillance for the Unit 1 fuel oil transfer pumps was not in verbatim compliance with the technical specification (TS) and therefore operation of the facility is in a condition prohibited by TS, and reportable in accordance with 10 CFR 50.73 (a) (2) (i) (A). Both Unit 1 emergency diesel generators (EDGs) are operable and within their surveillance requirements based on the performance of post maintenance testing (PMT) which was in verbatim compliance.

An evaluation determined this to be a legacy process issue due to interpretation of the TS regarding the acceptability of overlap testing. The design of the system in which the Unit 1 diesel oil transfer pumps do not auto start during normal operations, and the day tanks are gravity fed, is a design that is not conducive to verbatim compliance and is considered a contributing cause. Corrective actions taken include a change to surveillance procedures to eliminate any "overlap" testing.

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NARRATIVE**Description of the Event**

On February 19, 2009, the surveillance testing being performed for the Unit 1 EDG operability was called into question regarding verbatim compliance with the TS requirements. The Unit 1 TS surveillance (SR) 4.8.1.1.2a.3 verifies the fuel oil transfer pump (FOTP) [EIIS:DE] can be started and transfer fuel from the storage system [EIIS:DC] to the engine-mounted tank. Since the existing system design would not normally require a transfer pump to automatically start during the monthly surveillance run of the EDG, the procedure was revised to credit a gravity feed flow path verification and a separate manual start of the transfer pump on recirculation.

Compliance with the TS SR was accomplished in two steps as a form of overlap testing. One step validated the FOTP can be manually started and that the pump develops adequate discharge head while re-circulating fuel oil back to the storage tank. Another step validated there is a clear flow path for fuel oil from the storage tank, through the FOTP and to the engine-mounted day tank. The combination of these two steps ensured that the FOTP can be started, can provide flow, and that the flow path to the day tank is clear. Thus, the TS SR was satisfied.

Cause of the Event

Since the existing system design would not normally require a transfer pump to automatically start during the monthly surveillance run of the EDG, the procedure was revised in 1993 to credit a gravity feed flow path verification and a separate manual start of the transfer pump on recirculation.

An evaluation determined the cause of the event to be a legacy process issue due to interpretation of technical specifications regarding the acceptability of overlap testing. Additionally, the design of the system in which the Unit 1 diesel oil transfer pump does not automatically start during normal operations and the day tanks are gravity fed, is not conducive to verbatim compliance in accordance with TS 4.8.1.1.2a.3 and is considered a contributing cause.

Analysis of the Event

Although compliance with the TS SR was accomplished in two steps as a form of overlap testing, the surveillance was not completed verbatim in accordance with the TS and is considered to be an operation of the facility in a condition prohibited by TS; and reportable in accordance with 10 CFR 50.73(a)(2)(i)(A).

Both Unit 1 EDGs are operable and within the surveillance requirement based on the PMT of the day tank level switches. This testing verified start of the transfer pump on lo-lo level, opening of the solenoid valves and the transfer of fuel to the engine mounted tanks. This did not affect the Unit 2 EDGs. The Unit 2 fuel oil transfer system is a different design.

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Analysis of Safety Significance

Both Unit 1 EDGs are operable and within their surveillance requirement; the potential safety consequences of the event are low and there would have been no significant impact on the health and safety of the public.

Corrective Actions

The corrective actions and supporting actions were entered into the site corrective action program. Any changes to the proposed actions will be managed under the corrective action program.

1. Industry/Technical Specification Task Force (TSTF), TSTF-434-A, "Clarifying SR 3.0.1 Bases to state that Surveillance can be performed in steps" will be adopted for St. Lucie Technical Specifications, which will clarify the SR 4.0.1 Bases to state that surveillances can be performed in steps.
2. Revised Unit 1 procedure 1-OSP-59.01 A, "1A Emergency Diesel Generator Monthly Surveillance," to perform steps 6.1.3 and step 6.1.35.A. without overlap testing.
3. Revised Unit 1 procedure 1-OSP-59.01B "1B Emergency Diesel Generator Monthly Surveillance," to perform steps 7.1.3 and step 7.1.35.A. without overlap testing.
4. Both unit procedures 1(2)-OSP-01.02, "Reactor Coolant Gas Vent System Flow Path Verification" [or appropriate Operations Fill and Vent Procedure] will be revised to verify flow through the Reactor Coolant System vent paths during venting. If TSTF-434-A is incorporated prior to the associated unit's outage, then this action will not be required to be completed.
5. Both unit procedures 1(2)-OSP-69.13A/B, "ESF - 18 Month Surveillance for SIAS/CIS/CSAS - Train A/B," will be revised for each safety injection tank to demonstrate operability by verifying that each safety injection tank isolation valve opens automatically. If TSTF-434-A is incorporated prior to the associated unit's outage, then this action will not be required to be completed.

Similar Events

An extent of condition evaluation was performed to identify if similar overlap testing was being performed when TS specified a direct test. Two additional TS SRs on each unit were found where St. Lucie tests were performed by overlapping, contrary to TS wording.

A TS SR for the reactor coolant gas system vent path was tested as described in the TS up until 1997 for Unit 2. The Unit 1 procedures were changed to match the Unit 2 procedures in 2001. The 50.59 screening did not identify

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this as being a change to the intent of the TS requirement and therefore no changes to the TS were identified as required.

A TS SR for the safety injection tank (SIT) valves were verified to open on a safety injection signal as described in the TS SR until it was changed in 1999. The 50.59 screening for both Units did not identify this as being a change to the intent of the TS requirement, and therefore, no changes to the TS were determined to be required. The procedures and schedules will be changed to test these components in future outages, unless TSTF-434-A is incorporated into St. Lucie's TS basis prior to the associated unit's outage.