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FACIL:50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co. 05000335
AUTH.NAME AUTHOR AFFILIATION
WACHTEL,P.K. Florida Power & Light Co.
SAGER,D.A. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-009-00:on 911114,plant vent stack monitors removed from svc & Chemistry Dept not notified to sample for activity.Caused by personnel error.Gas sample obtained & analyzed & affected personnel counseled.W/911209 ltr.

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P.O. Box 128, Ft. Pierce, FL 34954-0128

FPL

December 9, 1991

L-91-328
10 CFR 50.73

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

Gentlemen:

Re: St. Lucie Unit 1
Docket No. 50-335
Reportable Event: 91-09
Date of Event: November 14, 1991
Removal of the Plant Vent Stack Monitors from Service
Resulted in a Condition Prohibited by Technical Specifications

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

Very truly yours,

D. A. Sager
Vice President
St. Lucie Plant

DAS/GRM/kw

Attachment

cc: Stewart D. Ebneter, Regional Administrator, USNRC Region II
Senior Resident Inspector, USNRC, St. Lucie Plant

DAS/PSL #576-91

IE24
1/1

FPL Facsimile of NRC Form 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
St. Lucie Unit 1	0 5 0 0 0 3 3 5	1 OF 0 3

TITLE (4) Removal of the Plant Vent Stack Monitors From Service Resulted in a Condition Prohibited by Technical Specifications due to Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
									N/A	0 5 0 0 0
1 1	1 4	9 1	9 1	-- 0 0 9	-- 0 0	1 2	0 9	9 1	N/A	0 5 0 0 0

OPERATING MODE (9)	6	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR : (Check one or more of the following) (11)							
POWER LEVEL (10)	0 0 0		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)
			20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
			20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text NRC Form 366A)
			20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
			20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
			20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Patricia K. Wachtel, Shift Technical Advisor	AREA CODE 4 0 7 4 6 5 - 3 5 5 0

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

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
☐ YES (If yes, complete EXPECTED SUBMISSION DATE)	☒ NO				

ABSTRACT (Limit to 1400 spaces. i.e. approximately fifteen single-space typewritten lines) (16)

On November 14, 1991 with St. Lucie Unit 1 in Mode 6 completing refueling requirements, a licensed utility operator noted that the Unit was in a condition prohibited by the Plant's Technical Specifications. The Plant Vent Stack Particulate Sampler, Iodine Sampler, and Noble Gas Activity monitor had been placed out of service and the Chemistry Department was not notified to sample for activity. Technical Specification 3.3.3.10 requires continuous sample collection with auxiliary sampling equipment to be performed if the plant vent is to be used as the effluent pathway. This condition existed for approximately twelve hours. During this time period there were no activities which could have resulted in an abnormal gaseous release.

The root cause of this event was a cognitive personnel error by utility-licensed operators for referencing an inappropriate Technical Specification pertaining to Radiation Monitoring Instrumentation.

Corrective actions taken were: 1) Chemistry obtained a gas sample and analyzed it for abnormal activity ; 2) Operations reviewed containment work for the period when the plant stack was unmonitored and found no activities which would have resulted in a release of airborne activity; 3) Operations Supervision counselled all licensed personnel to thoroughly review all the applicable Technical Specifications prior to taking a piece of equipment out of service; 4) Training Department incorporated this event into the Licensed Operator Requalification Training Program.

DESCRIPTION OF EVENT

On November 13, 1991, St. Lucie Unit 1 was in Mode 6 completing fuel movement. A clearance request had been issued on the Plant Vent Stack High Range Noble Gas Effluent Monitor (EIIS:IL) to allow maintenance personnel to install a new cable. The Plant Vent Stack Monitor was entered in the equipment out of service log at 1200 by a licensed-utility operator and reviewed by a second licensed-utility operator. St. Lucie Unit 1 Technical Specification 3.3.3.1 was referenced as the applicable Limiting Condition for Operation. This specification requires at least one of the noble gas effluent monitors of the plant vent system (EIIS:VL) to be in service during Modes 1, 2, 3, and 4.

At approximately 0000 on November 14, 1991, a different licensed-utility operator was in the process of taking his twice shiftly logs when he noted that the Plant Vent Stack Monitor was not in service. He checked the equipment out of service log and found that the plant stack monitor was entered as being out of service but an inappropriate Technical Specification was referenced. Technical Specification 3.3.3.10 requires one channel each of the Particulate Sampler, the Iodine Sampler, and the low range Noble Gas Activity Monitor to be in service at all times; otherwise, continuously collect samples for analysis until the Plant Vent Stack System Monitor is back in service. Chemistry was notified of the situation and they, in turn, notified maintenance personnel to restore power to the monitor to allow a sample to be taken. The Plant Vent Stack Monitor was declared back in service at 0300 and Chemistry drew a gas sample indicating conditions were normal for the plant mode at that time.

CAUSE OF EVENT

The root cause of the event was cognitive personnel error by utility-licensed operators. Technical Specification 3.3.3.1 requires one channel of the noble gas effluent monitor of the plant vent system to be in service during Modes 1,2,3, and 4; whereas Technical Specification 3.3.3.10 requires particulate, iodine and noble gas monitoring at all times. All applicable Technical Specifications were not reviewed prior to placing the Plant Vent Stack Monitor out of service and an inappropriate Technical Specification was referenced. There were no unusual control room environment characteristics which may have contributed to the event.

ANALYSIS OF EVENT

This event is reportable under 10 CFR 50.73.a.2.i.B,as "any operation or condition prohibited by the plant Technical Specifications." In the event that Technical Specification 3.3.3.10 cannot be met, effluent releases via the plant stack may continue for up to thirty days provided grab samples are taken at least once per eight hours and these samples are analyzed for isotopic activity within twenty four hours and samples are continuously collected with auxiliary sampling equipment as required in Technical Specification Surveillance Requirement 4.11.2.1.2.

The radioactive gaseous effluent instrumentation is provided to monitor and control, as applicable, the releases of radioactive materials in gaseous effluents during actual or potential releases of gaseous effluents. During the time in which the Plant Vent Stack Monitor was out of service, the activities being performed on Unit 1 were the same as those that had been performed for the

ANALYSIS OF EVENT, cont.

previous three days. The reactor was being refueled and a containment purge was under way. During the previous days of refueling, there were no abnormal releases detected from the plant stack. Also, the gas sample drawn by Chemistry after the monitor was placed back into service did not indicate any abnormalities. Additionally, due to required instrument monitoring in the form of operator logs, this event could not have gone undetected for greater than twenty four hours. Therefore, the health and safety of the public was not affected by this event.

CORRECTIVE ACTIONS

1. Chemistry obtained a gas sample and analyzed it for abnormal activity. The results indicated normal conditions for the plant mode at that time.

2. Operations reviewed the containment work that had been under way for the period when the Plant Stack was unmonitored and found no work activities which would have resulted in an abnormal release of airborne activity.

3. Licensed personnel were counselled by Operations Supervision to thoroughly review all the applicable Technical Specifications prior to taking a piece of equipment out of service.

4. The Training Department incorporated this event into the Licensed Operator Requalification Training Program.

ADDITIONAL INFORMATION

Component Failure

None

Previous Similar Events

Previous events in which Technical Specification equipment was placed out of service incorrectly due to personnel error include:

LER 335-87-009, "Equipment Failure and Personnel Error Result in Technical Specification Radiation Monitors Inoperable"
LER 389-89-006, "Removing Diesel Generator from Service for Preventive Maintenance Results in a Condition Prohibited by Technical Specifications due to Personnel Error".