

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9511290068      DOC. DATE: 95/11/01      NOTARIZED: NO      DOCKET #  
 FACIL: 50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co.      05000335  
 AUTH. NAME      AUTHOR AFFILIATION  
 LAVELLE, S.      Florida Power & Light Co.  
 SAGER, D.A.      Florida Power & Light Co.  
 RECIP. NAME      RECIPIENT AFFILIATION

SUBJECT: LER 95-009-00: on 951019, discovered TS scheduled surveillance was missed due to personnel error. Operations supervisor issued memo & counseled & disciplined involved individual. W/951118 ltr.

DISTRIBUTION CODE: IE22T      COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4  
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

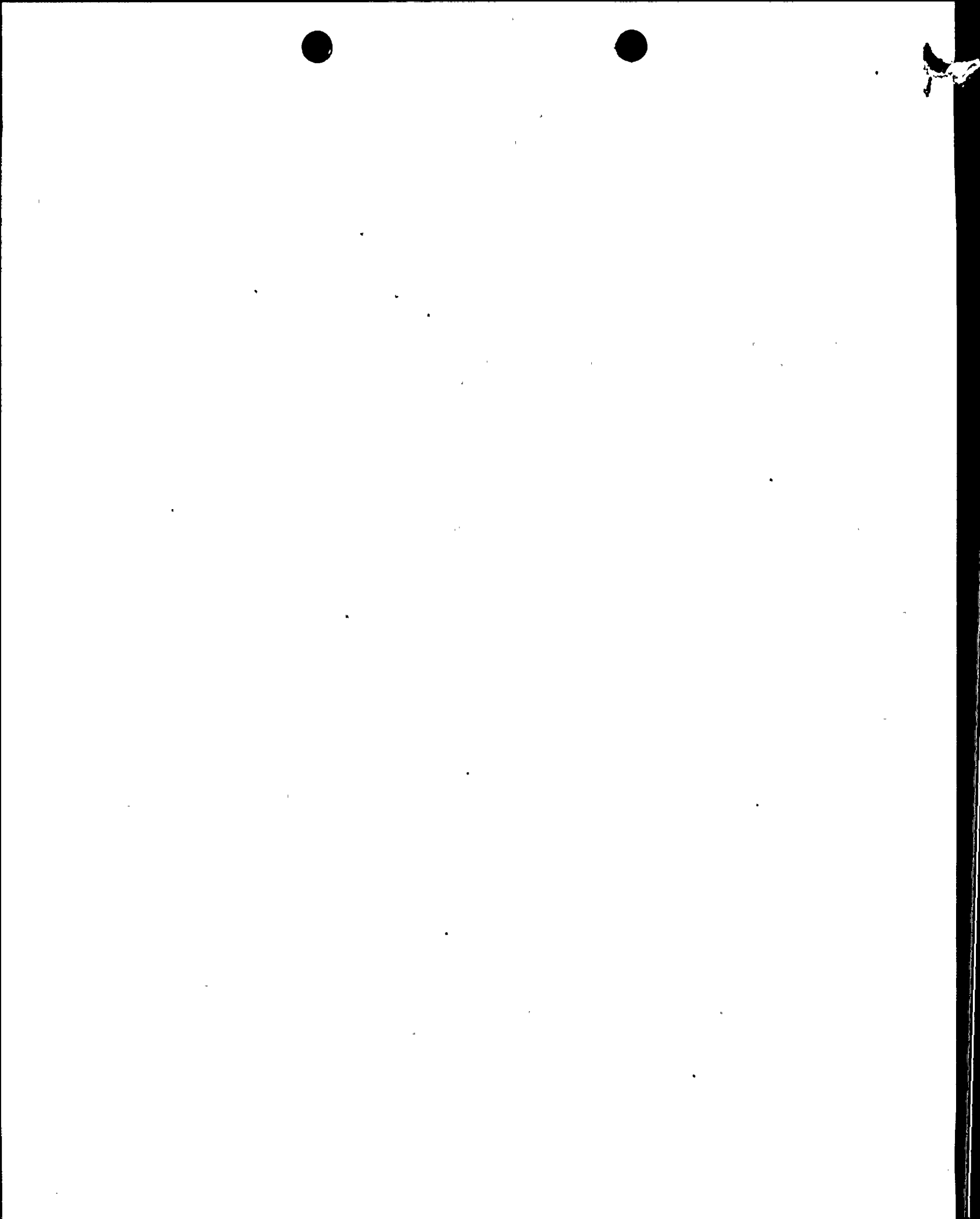
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L-95-305  
10 CFR 50.73

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

Re: St. Lucie Unit 1  
Docket No. 50-335  
Reportable Event: 95-009  
Date of Event: October, 19, 1995  
Missed Technical Specification Scheduled Surveillance  
Due to Personnel Error

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. Seger  
Vice President  
St. Lucie Plant

DAS/SL

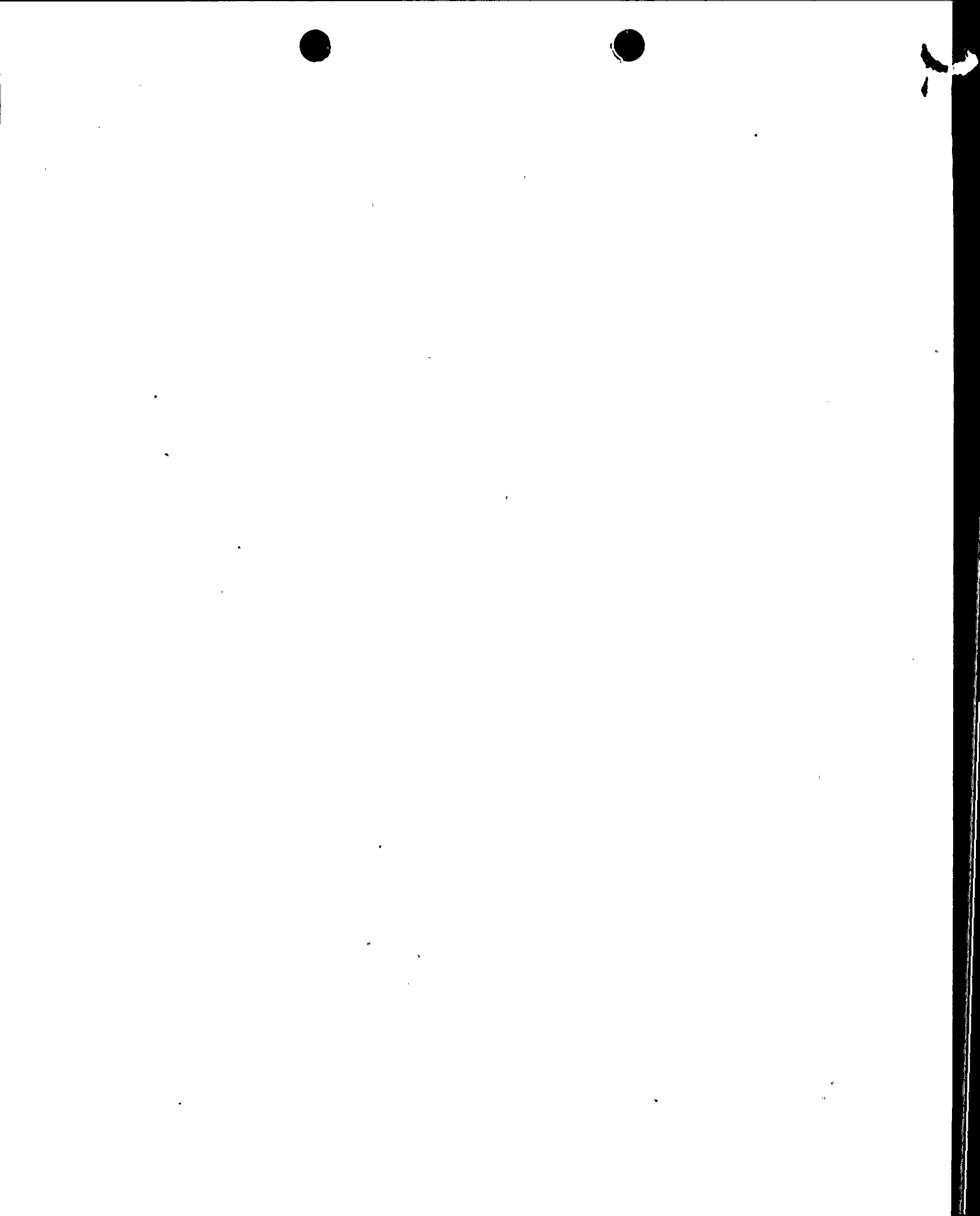
Attachment

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

270107

9511290068 951101  
PDR ADOCK 05000335  
S PDR

an FPL Group company



**LICENSEE EVENT REPORT (LER)**

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 60.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-8 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20565-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

ST LUCIE UNIT 1

DOCKET NUMBER (2)

05000335

PAGE (3)

1 OF 3

TITLE (4)

Missed Technical Specification Scheduled Surveillance 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 NAME	DOCKET NUMBER
10	19	95	95	009	0	11	01	95	N/A	
									FACILITY NAME	DOCKET NUMBER
									N/A	
									FACILITY NAME	DOCKET NUMBER
									N/A	

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)				
1	096	20.2201(b)	20.2203(a)(2)(v)	<input checked="" type="checkbox"/>	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)		50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)		50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)		50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.38(a)(1)		50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.38(a)(2)		50.73(a)(2)(vii)	

**LICENSEE CONTACT FOR THIS LER (12)**

NAME

Sean Lavelle

TELEPHONE NUMBER (Include Area Code)

(407) -467-7160

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS

**SUPPLEMENTAL REPORT EXPECTED (14)**

YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/>	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
				11	18	95

**ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)**

On October 20, 1995, Unit 1 was in Mode 1 at 96% reactor power. The Control Room Supervisor, while reviewing the previous days surveillance documentation, discovered that the verification of Control Element Assembly (CEA) position indication, as required by Technical Specification 4.1.3.3, had not been performed on the day shift of October 19, 1995.

The surveillance was not performed at its scheduled time due to personnel error. The utility licensed operator had initialed the check sheet used to track Technical Specification surveillances without actually performing the surveillance.

The surveillance was satisfactorily performed approximately nine hours beyond the frequency allowed by the Technical Specification on the midnight shift of October 20, 1995. At all times the CEAs were at the "Full Out" position, as is indicated on the control board Core Mimic.

Corrective Actions implemented as a result of this event include: 1) verified CEA position indication. 2) verified other requirements signed for by the utility licensed operator on day shift were completed. 3) a memo was issued to all operators reiterating plant policy regarding documentation of work activities. 4) the utility licensed operator was counseled and disciplined in accordance with plant policy. 5) surveillance check sheet 1 was revised to reference the CEA log sheet. 6) Training will review the event in licensed operator requalification.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
ST. LUCIE UNIT 1	05000335	95	-- 009	-- 0	2 OF 3

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

**DESCRIPTION OF THE EVENT**

Technical Specification 4.1.3.3, verification of Control Element Assembly (CEA)(EIS:AA) position indication requires that read switch position indication and pulse counting position indication be verified to be within four and one half inches at least once per twelve hours. The surveillance is performed using Administrative Procedure 1-0010125 check sheet 1 "Surveillances Performed Each Shift" and the "Control Room Log Sheet CEA Position".

On the day shift of October 19, 1995 with the unit in Mode 1 and reactor power at 96% , Technical Specification 4.1.3.3 was not performed. The day shift utility licensed operator did not complete the CEA log. Upon review of the documentation from the previous day, on the midnight shift of October 20, 1995, the control room supervisor discovered the incomplete CEA log sheet. He immediately verified that the CEAs were within their Technical Specification surveillance requirements and at their "Full Out" position.

**CAUSE OF THE EVENT**

The root cause of the event was cognitive personnel error in that the utility licensed operator did not verify CEA position indication in the time frame allowed by Technical Specifications. He initialed Check Sheet 1 of AP-1-0010125 indicating that the surveillance was performed without completing the CEA log. Contributing to the event was that the operator completed Check Sheet 1 from memory , instead of signing for each surveillance as it was completed.

**ANALYSIS OF THE EVENT**

This event is reportable under 10 CFR 50.73 (a)(2)(i)(B) as, "any operation or condition prohibited by the plant's Technical Specifications". NUREG 1022, Event Reporting Guidelines 10 CFR 50.72 and 50.73, states that a missed surveillance is reportable when the surveillance interval plus the allowable interval extension plus the Limiting Condition for Operation (LCO) action statement time is exceeded. The surveillance interval was 12 hours with an extension of 3 hours and operation outside of this action statement gave one hour to place the unit in a mode where the LCO did not apply. This event is reportable due to exceeding the allowed frequency. The surveillance was completed satisfactorily prior to the discovery of the previous surveillance not being performed and it was not necessary to place the unit in a mode where the action statement did not apply.

Per the Technical Specification Bases 3/4.1.3 for indicator position verification, "Operability of at least two CEA position indicator channels is required to determine CEA positions and thereby ensure compliance with the CEA alignment and insertion limits. The CEA "Full In" and "Full Out" limits provide an additional independent means for determining the CEA positions when the CEAs are at either their fully inserted or fully withdrawn positions. Therefore, the action statements applicable to inoperable CEA position indicators permit continued operations when the position of CEAs with inoperable position indicators can be verified by the "Full In" or "Full Out" limits". In this particular incident all CEAs were at or above their "Full Out" limit of 129 inches. During the time the position indicators were not verified by the CEA log sheet, the lights were illuminated on the Core Mimic, which displays the "Full Out" limits on Reactor Control Board 104 in view of the control room crew.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
ST. LUCIE UNIT 1	5000335	95	009	0	3 OF 3

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

**CORRECTIVE ACTIONS**

- 1) The control room supervisor immediately verified CEA position indications were in accordance with Technical Specification.
- 2) Other surveillances and requirements signed on Check Sheet 1 of AP-1-0010125, by the utility licensed operator in this event, were verified as performed.
- 3) The Operations Supervisor has issued a memo to operators reiterating plant policy regarding documentation of work activities.
- 4) The operator in this event was counseled and disciplined in accordance with plant policy.
- 5) The surveillance Check Sheet 1 was revised to reference the accompanying CEA log sheet.
- 6) Training will review this event in licensed operator requalification.

**ADDITIONAL INFORMATION**

**Component Failures**

No component failures were involved in this event.

**Previous Similar Events**

Similar events that resulted in missed Technical Specification scheduled surveillances are:

- LER 335-90-002 "Missed Surveillance on 125 Volt DC Batteries Result in Technical Specification Violation Due to Personnel Error."
- LER 389-91-005 "Missed Surveillance for Safety Injection Tank Water Level and Pressure Channel Functional Test Due to Personnel Error."
- LER 389-95-003 "Missed Technical Specification Scheduled Surveillance Due to Procedural Deficiency."