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POWELL,D.R. Florida Power & Light Co.
PLUNKETT,T.F. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 90-020-01:on 901013,surveillance interval of Tech Spec 4.8.2.1 exceeded due to personnel error.Personnel involved counselled & Procedure 4-OSP-201.3 revised.W/911001 ltr.

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OCT 0 1 1991

L-91-260
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 3 & 4
Dockets No. 50-250 and 50-251
Reportable Event: 90-020-01
Date of Event: October 13, 1990
Missed Technical Specification required Surveillance on Station Batteries Due to Personnel Error

The attached revision to Licensee Event Report 250-90-020 is being provided in accordance with the requirements of 10 CFR 50.73 and the guidance of NUREG 1022, Supplement 1, item 19.1 to provide additional information on the actions taken to prevent recurrence.

Very truly yours,

T. F. Plunkett
Vice President
Turkey Point Nuclear

TFP/DPS/ds

enclosures

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

IE22

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
TURKEY POINT UNIT 3	05000250	1 OF 3

TITLE (4)

MISSED TECHNICAL SPECIFICATION REQUIRED SURVEILLANCE ON STATION BATTERIES DUE TO PERSONNEL ERROR

EVENT DATE (5)			LER NUMBER(6)			RPT DATE (7)			OTHER FACILITIES INV. (8)	
MON	DAY	YR	YR	SEQ #	R#	MON	DAY	YR	FACILITY NAMES	DOCKET # (S)
10	13	90	90	020	01	10	01	91	Turkey Point Unit 4	05000251

OPERATING MODE (9)	1	10 CFR 50.73(a)(2)(i)
POWER LEVEL (10)	100	

LICENSEE CONTACT FOR THIS LER (12)

David R. Powell, Superintendent of Licensing	TELEPHONE NUMBER: 305-246-6559

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	NPRDS?	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	NPRDS?

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

ABSTRACT (16)

On October 13, 1990, at approximately 1000 EDT, the 24 hour plus 6 hour (i.e., 25 percent grace - TS 4.0.1) surveillance interval of Technical Specification (TS) 4.8.2.1 a. was exceeded. This event was discovered at 1230 EDT, during the review of Unit 4 log sheets in accordance with procedure 4-OSP-201.3, "NPO Daily Logs." The vital DC station batteries were declared inoperable, both units entered TS 3.0.1, and electricians were dispatched to take the required battery pilot cell specific gravity readings. At 1319 EDT, the required surveillance was completed and verified acceptable and TS 3.0.1 was exited. This event was caused by cognitive personnel error in that plant non-licensed personnel responsible for taking and recording the required readings were preoccupied with resolution of a TS limiting condition for operation (LCO). The surveillance could have still been performed within its time requirements except for an inadequate review of required surveillances during shift turnover by a licensed operator. Applicable plant procedures were revised to preclude recurrence of this event. A management review of the generic problem of surveillance scheduling and tracking determined that a Surveillance Tracking Program was needed to reduce the number of missed surveillances. This program was implemented on August 23, 1991.

I. EVENT DESCRIPTION

On October 13, 1990, at approximately 1000 EDT, the 24 hour plus or minus 6 hour (i.e., 25 percent grace - TS 4.0.1) surveillance interval of Technical Specification (TS) 4.8.2.1 a. was exceeded.

This event was discovered at 1230 EDT, by the oncoming Assistant Plant Supervisor - Nuclear (APSN), during the review of Unit 4 log sheets in accordance with procedure 4-OSP-201.3, "NPO Daily Logs," The daily surveillance of the Unit 3 and Unit 4 shared station batteries is covered by procedure 4-OSP-201.3. The vital DC station batteries were declared inoperable, both units entered TS 3.0.1, and electricians were dispatched to take the required battery pilot cell specific gravity readings.

At 1319 EDT, the required surveillances were completed and verified and TS 3.0.1 was exited.

II. EVENT CAUSE

1. Root Cause

   This event was caused by cognitive personnel error in that non-licensed plant personnel responsible for taking the required readings and the non-licensed plant personnel responsible for recording the required readings were involved with corrective maintenance necessary to return TS required equipment to service within the time permitted by the applicable TS limiting condition for operation (LCO).

2. Contributing Causes include:

   a. The Unit 4 Turbine Operator (non-licensed operator) responsible for collecting the data for procedure 4-OSP-201.3 failed to inform the Assistant Plant Supervisor - Nuclear (APSN) that the battery readings had not been received.

   b. An inadequate log sheet review was made by the APSN. The APSN should have noticed the open surveillance during the review of the logs and initiated actions to have the surveillance performed.

III. EVENT SAFETY ANALYSIS

The late surveillance of the station batteries made the batteries technically inoperable. The surveillance, completed at 1319 EDT, verified that the specific gravity, level, and temperature of the pilot cells were within their required limits. Therefore, the parameters measured in this surveillance indicate that sufficient stored charge was available for the batteries to perform their required safety function.

IV. CORRECTIVE ACTIONS

1. Procedure 4-OSP-201.3 was revised to require verification of start and completion of the station batteries surveillance within a set time interval on a daily basis.

2. All non-licensed operator rounds sheets were reviewed for Technical Specification required surveillances. Those required by Technical Specifications have been highlighted for the benefit of the operators performing the rounds and to aid the APSN in his review.

3. The operators involved with this event have been counselled.

4. This event and the resulting procedural changes were reviewed with all applicable personnel.

5. A management review of the generic problem of surveillance scheduling and tracking was performed to determine applicable corrective actions to reduce the number of missed surveillances. This review, completed on January 14, 1991, recommended implementation of a Surveillance Tracking Program. The Surveillance Tracking Program was implemented on August 23, 1991.

V. ADDITIONAL INFORMATION

A. Similar Events

Other LERs have been submitted involving missed surveillances, however, none of the root causes for these previous events were similar to the root cause of this event. Thus none of the corrective actions taken for these previous similar events were applicable to the event reported in this LER.

B. Equipment Failures

None