

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8705050272 DOC. DATE: 87/04/29 NOTARIZED: NO DOCKET #
 FACIL: 50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co. 05000335
 AUTH. NAME AUTHOR AFFILIATION
 WEST, D. H. Florida Power & Light Co.
 WOODY, C. O. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-009-00: on 870412, ECCS emergency exhaust fan radiation monitor failed resulting in Tech spec radiation monitors inoperable. Caused by equipment & personnel error. Both radiators installed & personnel conselled. W/870429 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	PD2-2 LA	1 1	PD2-2 PD	1 1
	TOURIGNY, E	1 1		
INTERNAL:	ACRS MICHELSON	1 1	ACRS MOELLER	1 1
	AEOD/DOA	1 1	AEOD/DSP/ROAB	2 2
	AEOD/DSP/TPAB	1 1	NRR/DEST/ADE	1 0
	NRR/DEST/ADS	1 0	NRR/DEST/CEB	1 1
	NRR/DEST/ELB	1 1	NRR/DEST/ICSB	1 1
	NRR/DEST/MEB	1 1	NRR/DEST/MTB	1 1
	NRR/DEST/PSB	1 1	NRR/DEST/RSB	1 1
	NRR/DEST/SCB	1 1	NRR/DLPQ/HFB	1 1
	NRR/DLPQ/GAB	1 1	NRR/DOEA/EAB	1 1
	NRR/DREP/EPB	1 1	NRR/DREP/RAB	1 1
	NRR/DREP/RPB	2 2	NRR/PMAS/ILRB	1 1
	NRR/PMAS/PTSB	1 1	<u>REC FILE</u> 02	1 1
	RES SPEIS, T	1 1	RGN2 FILE 01	1 1
EXTERNAL:	EG&G GROH, M	5 5	H ST LOBBY WARD	1 1
	LPDR	1 1	NRC PDR	1 1
	NSIC HARRIS, J	1 1	NSIC MAYS, G	1 1

TOTAL NUMBER OF COPIES REQUIRED: LTTR 41 ENCL 39

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) St. Lucie, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 3 5	PAGE (3) 1 OF 0 4
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TITLE (4) **EQUIPMENT FAILURE AND PERSONNEL ERROR RESULT IN TECH. SPEC. RADIATION MONITORS INOPERABLE**

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		
0 4	1 2	8 7	8 7	0 0 9	0 0	0 4	2 9	8 7	NA		
									DOCKET NUMBER(S) 0 5 0 0 0		

OPERATING MODE (9) **2**

POWER LEVEL (10) **0 0 0**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 50.36(e)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.36(e)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	<input checked="" type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)
<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)	Special Report
<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(vii)(B)	
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME D. H. West, Shift Technical Advisor	TELEPHONE NUMBER
	AREA CODE: 3 0 5 4 NUMBER: 6 5 - 3 5 5 0

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
X	I L	R J X	E 0 7 0	Y					
X	I L	C P U	E 0 7 0	Y					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

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

ABSTRACT

During post refueling power ascension the 1A Emergency Core Cooling System (ECCS) Emergency Exhaust Fan Radiation Monitor failed. Chemistry personnel realigned the Fuel Handling Building (FHB) Exhaust Stack Radiation Monitor to take its place. Operations was unaware of the realignment and the FHB Ventilation System was operated for 5 days without an operable radiation monitor.

The cause of the 1A ECCS Exhaust Fan Radiation Monitor failure was equipment failure. The cause of the FHB Exhaust Stack Radiation Monitor inoperability was personnel error.

There was no significant release of activity from the FHB while its radiation monitor was inoperable.

Both Radiation Monitors were completely restored to service. The individuals involved were counselled. The plant Training Department will evaluate this event.

This event is reportable as a Special Report and as a Licensee Event Report (see text).

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11



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) St. Lucie, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 3 5	LER NUMBER (6)				PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 7	- 0 0 9	- 0 0	0 2	OF	0 4

TEXT (If more space is required, use additional NRC Form 368A's) (47)

DESCRIPTION OF EVENT

On April 12, 1987, St. Lucie Unit 1 was in Mode 2 at 10E-2% power for post refueling physics testing. During his normal rounds a plant Chemistry technician discovered that the Reactor Auxiliary Building (RAB) 1A Emergency Core Cooling System (ECCS) Emergency Exhaust Fan Radiation Monitor (EIIS:IL) had failed. Operations personnel were notified and they immediately declared the monitor out of service as of 1015 hours. The action Statement of Technical Specification 3.3.3.1.b was entered which required the monitor to be returned to service within 72 hours or an alternative monitoring method be established. On April 15, 1987 the troubleshooting of the 1A ECCS Emergency Exhaust Fan Radiation Monitor was still unsuccessful. Consequently by 1000 hours Chemistry personnel had routed a temporary sample line from the 1A ECCS Emergency Exhaust Fan ducting to the Fuel Handling Building (FHB) Ventilation System Exhaust Stack Radiation Monitor (EIIS:IL). This was intended to satisfy the requirements of Tech. Spec. 3.3.3.1.b. Chemistry personnel informed Operations personnel that the FHB Exhaust Stack Radiation Monitor would no longer be monitoring the FHB Exhaust and that the fans should be secured. Accordingly the FHB Exhaust Stack Radiation Monitor should have been placed out of service using proper administrative controls. The FHB Exhaust Ventilation System should have either been secured or periodically sampled in accordance with Tech. Spec. 3.3.3.10.b. However, the Operations individuals informed forgot about the change in FHB Radiation Monitor status. On April 20, 1987, a Chemistry technician noted that the FHB Ventilation Fans were still running. He knew that no extra samples were being taken on FHB Ventilation. The Chemistry technician immediately informed Operations personnel of the out of service FHB Exhaust Stack Radiation Monitor. Operations personnel immediately secured all FHB Ventilation fans by 0800 hours April 20, 1987. Subsequently, repairs were completed and the 1A ECCS Emergency Exhaust Fan Radiation Monitor was repaired and returned to service at 1600 hours April 20, 1987. The FHB Ventilation System and its associated radiation monitor was also restored to service at that time.

CAUSE OF EVENT

The cause of the 1A ECCS Emergency Exhaust Fan Radiation Monitor failure was equipment failure. Several components including a power supply and a CPU circuit card were replaced. See "Failed Component Information."

The failure to declare the FHB Exhaust Stack Radiation Monitor out of service and implement the applicable Tech. Spec. Action Statement was cognitive personnel error on the part of utility licensed operator personnel.

This personnel error did not involve a procedure and there were no unusual characteristics of the work location which directly contributed to the error.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) St. Lucie, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 3 5	LER NUMBER (6)						PAGE (3)			
		YEAR	SEQUENTIAL NUMBER		REVISION NUMBER						
		8 7	- 0 0 9		- 0 0		0 3	OF	0 4		

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

ANALYSIS OF EVENT

This event is reportable under 10 CFR 50.73(a)(2)(1)(B) as an operation or condition prohibited by the plant's Technical Specifications. Tech. Spec. 3.3.3.10.b requires periodic samples when the FHB Ventilation System is operated with its radiation monitor unavailable. This event is also reportable as a Special Report per Tech. Spec. 3.3.3.1.b because the 1A ECCS Emergency Exhaust Fan Radiation Monitor was out of service greater than 72 hours.

Although the FHB Exhaust Stack Radiation Monitor was out of service for 118 hours before the FHB Ventilation System was secured, the safety consequences of this event were negligible. This is supported by the following: the FHB Area Radiation Monitors were operable during this period; grab sample capability was always available and the FHB Radiation Monitor could have been quickly restored at any time if needed; no FHB work involving irradiated fuel took place during this period; routine FHB Exhaust Ventilation samples taken before and after the period of unmonitored operation were normal. Therefore, the health and safety of the public was not affected by this event.

CORRECTIVE ACTIONS

1. The FHB Exhaust Stack Radiation Monitor and FHB Ventilation System were completely restored to service.
2. The 1A ECCS Emergency Exhaust Fan Radiation Monitor was completely restored to service.
3. The personnel involved have been counselled regarding the operability of plant radiation monitoring systems.
4. The plant Training Department will evaluate this event to determine appropriate training requirements and methods.
5. A new procedure will be created to address alternative methods of performing Tech. Spec. required radiation monitoring.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) St. Lucie, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 3 5	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 7	- 0 0 9	- 0 0	0 4	OF 0 4

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

ADDITIONAL INFORMATION

Failed Component Information

The 1A ECCS Emergency Exhaust Fan Radiation Monitor is an Eberline model SPING-4. The power supply replaced was an Eberline 12 vdc BCM-2 power supply. The CPU circuit card replaced was an Eberline part number 10889-805.

Previous Similar Events

This is the first Licensee Event Report involving out of service radioactive effluent monitors.



APRIL 29 1987

L-87-191
10 CFR 50.73

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

Gentlemen:

Re: St. Lucie Unit I
Docket No. 50-335
Reportable Event: 87-09
Date of Event: April 12, 1987
Equipment Failure and Personnel Error Result in
Tech. Spec. Radiation Monitors Inoperable

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

Very truly yours,

H. M. Paduano Jr.
for C. O. Woody
Group Vice President
Nuclear Energy

COW/GRM/gp

Attachment

cc: Dr. J. Nelson Grace, Regional Administrator, Region II, USNRC
Senior Resident Inspector, USNRC, St. Lucie Plant

*IEER
11*

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