

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8707150631 DOC. DATE: 87/07/09 NOTARIZED: NO DOCKET #
 FACIL: 50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co. 05000335
 AUTH. NAME AUTHOR AFFILIATION
 MENDOZA, V. N. Florida Power & Light Co.
 WOODY, C. O. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-012-00: on 870609, discovered that component cooling water 1a & 1b HX outlet cross-tie valves were in open position. Caused by personnel error. Valves closed. W/870709 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4
 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	2 2
	AEOD/DOA	1 1	AEOD/DSP/ROAB	2 2
	AEOD/DSP/TPAB	1 1	DEDRO	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/SGB	1 1
	NRR/DLPQ/HFB	1 1	NRR/DLPQ/QAB	1 1
	NRR/DOEA/EAB	1 1	NRR/DREP/RAB	1 1
	NRR/DREP/RPB	2 2	NRR/PMAS/ILRB	1 1
	NRR/PMAS/PTSB	1 1	<u>REG FILE</u> 02	1 1
	RES DEPY GI	1 1	RES TELFORD, J	1 1
	RES/DE/EIB	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

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 3
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TITLE (4) **LOSS OF COMPONENT COOLING WATER REDUNDANCY BECAUSE OF CROSSTIE VALVES BEING IN THE OPEN POSITION 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 0		
0 6	0 9	8 7	8 7	0 1 2	0 0	0 7	0 9	8 7				0 5 0 0 0 0		

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)											
POWER LEVEL (10) 1 0 0	20.402(b)			20.405(c)			50.73(a)(2)(iv)			73.71(b)		
	20.406(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)(vi)			OTHER (Specify in Abstract below and in Text, NRC Form 366A)		
	20.406(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)					
20.406(a)(1)(v)			50.73(a)(2)(iii)			50.73(a)(2)(ix)						

LICENSEE CONTACT FOR THIS LER (12)									
NAME Victor N. Mendoza, Shift Technical Advisor							TELEPHONE NUMBER		
							AREA CODE		
							3 1 0 5 4 6 1 5 - 3 1 5 1 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	

SUPPLEMENTAL REPORT EXPECTED (14)							EXPECTED SUBMISSION DATE (15)		
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO							MONTH	DAY	YEAR

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

ABSTRACT

On June 19, 1987, St. Lucie Unit #1 was in Mode 1, 100% power, and at steady state conditions. All control stations were in normal operating mode. At 0124 hours, the Reactor Control Operator (RCO) was performing a monthly pump surveillance run for the 1B component cooling water (CCW) pump. During this surveillance run, it was discovered that the 1A and 1B CCW heat exchanger outlet cross-tie valves were in the open position. The normal position for these valves is closed. The operator immediately performed a valve alignment verification and closed the valves. The root cause of the event was a cognitive personnel error by utility licensed operators who failed to have proper administrative control on these valves. The immediate corrective action was to close the valves. The event was terminated at 0130 hours. No other system malfunction resulted from this event. This event is reportable under the Code of Federal Regulations 10 CFR 50.73 (a) (2) (i) (B), "Any event or condition prohibited by plant's Technical Specifications."

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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 1 2	- 0 0	0 2	OF	0 3

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

DESCRIPTION OF EVENT

On June 19, 1987, St. Lucie Unit #1 was in Mode 1, 100% power, and at steady state conditions. At 0124 hours, the Reactor Control Operator (RCO) was performing a monthly pump surveillance run for the 1B component cooling water (CCW) (EIIS:CC) pump. The 1B CCW pump discharge valve was throttled to obtain 4000 GPM flow on the "B" header, as required by the procedure. As the valve was throttled, the RCO noticed that the "A" header flow was also decreasing concurrent with the "B" header. The RCO notified the Assistant Nuclear Plant Supervisor (ANPS) and the ANPS immediately instructed the Nuclear Operator to perform a valve alignment verification. During this verification, it was discovered that the 1A and 1B CCW heat exchanger outlet cross-tie valves V-14169 (which is a normally locked closed valve) and V-14439 (which is a normally closed valve) were in the open position. Both valves were then immediately closed and independently verified to be closed. The normal CCW valve alignment was restored to its normal operations line-up. The pump surveillance run was then resumed and noted as satisfactory. No other abnormalities in the system were noted after the restoration of the CCW system valve alignment. The event was terminated at 0130 on June 19, 1987. No other system malfunctions were observed during the entire event.

CAUSE OF EVENT

On June 8, 1987, the 1B CCW heat exchanger was scheduled for repairs. A clearance was issued for all valves and related equipment required to isolate the 1B CCW heat exchanger. The cross-tie valves V-14169 (which is normally locked closed) and V-14439 (which is normally closed) were opened to allow both the "A" and "B" trains of the CCW system (EIIS:CC) to be in service while the 1B CCW heat exchanger was being repaired. Neither of the cross-tie valves were listed on the clearance. The utility licensed operator in charge of reviewing the clearance prior to issuance decided not to include these valves in the clearance as these valves were not required for maintenance boundary isolation. He opted to administratively control valve V-14169 by listing this valve in the locked valve deviation log as being in the open position. However, the locked valve deviation log was not reviewed by operations personnel. Thus, it was not noted in the clearance that valves V-14169 and V-14439 were not in their normal closed positions. After the repairs to the heat exchanger were completed on June 9, 1987, all the valves and related equipment on the clearance were released and independently verified as being restored to the required operating positions. Since valves V-14169 and V-14439 were not listed on the clearance, they were not restored to their normal position as part of the clearance release process, nor was independent verification called for.

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)		
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		8 7	- 0 1 2	- 0 0	0 3	OF	0 3

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

The root cause of the event was cognitive personnel error by utility licensed operators who failed to have proper administrative control on valves that were positioned in other than their normal operating positions. There were no procedure deficiencies or unusual characteristics of the work location that directly contributed to this event.

ANALYSIS OF EVENT

The event is reportable under 10 CFR 50.73 (a) (2) (i) (B), "Any event or condition prohibited by the plant's Technical Specifications." Technical Specification 3.7.3.1 requires "at least two independent component cooling water loops shall be operable."

This event resulted in a loss of component cooling system (EIIIS:CC) redundancy. However, the loss of redundancy was discovered within 10 days during performance of a routine monthly surveillance. Redundancy was completely restored within six (6) minutes of discovery. There were no other abnormalities in the system during the event. All plant safety functions were met throughout this event. At no time during this event was the health and safety of the public endangered.

CORRECTIVE ACTIONS

1. Valve V-14169 was restored to its locked closed position and valve V-14439 was closed. Independent verification of valve proper position was performed.
2. The plant training group will evaluate this item to determine appropriate training requirements and methods.
3. The responsible supervisor has been instructed to include these valves in future clearances to ensure restoration.

ADDITIONAL INFORMATION

Failed component identification: There were no failed components during this event.

PREVIOUS SIMILAR EVENT

See LER #335-85-02 for a previous valve mispositioning event.

FPL

JULY 9 1987

L-87-284

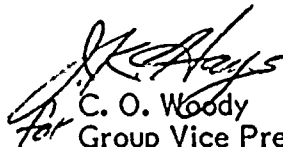
U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

Gentlemen:

Re: St. Lucie Unit No. 1
Docket No. 50-335
Reportable Event: 87-12
Date of Event: June 9, 1987
Loss of Component Cooling Water System Redundancy

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,


for C. O. Woody
Group Vice President
Nuclear Energy

COW/GRM/cn

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

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