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ACCESSION NBR: 8907250172 DOC. DATE: 89/07/14 NOTARIZED: NO DOCKET #
 FACIL: 50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co. 05000335
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 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-002-00: on 890614, inoperability of 1B diesel fuel oil
 sys caused by misaligned valve due to personnel error.
 W/8 ltr.

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U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

P.O. Box 14000, Juno Beach, FL 33408-0420

JULY 14 1989

L-89-242
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: 89-02
Date of Event: June 14, 1989
Misaligned Valve Caused Inoperability of the
1B Diesel Fuel Oil System 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,

C. O. Woody
Acting Senior Vice President - Nuclear

COW/JRH/cm

Attachment

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

8907250172 890714
PDR ADOCK 05000335
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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) **Misaligned Valve Caused Inoperability of the 1B Diesel Fuel Oil System 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)			
0	6	14	8	9	8	9	0	7	14	N/A			0 5 0 0 0		
0	6	14	8	9	0	2	0	7	14				0 5 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	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(c)	<input type="checkbox"/> 60.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 60.36(c)(1)	<input type="checkbox"/> 60.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 60.36(c)(2)	<input type="checkbox"/> 60.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 368A)						
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 60.73(a)(2)(ii)	<input type="checkbox"/> 60.73(a)(2)(viii)(A)							
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 60.73(a)(2)(iii)	<input type="checkbox"/> 60.73(a)(2)(viii)(B)							
	<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 60.73(a)(2)(iii)	<input type="checkbox"/> 60.73(a)(2)(ix)							

LICENSEE CONTACT FOR THIS LER (12)

NAME Charles D. Holifield, Shift Technical Advisor	TELEPHONE NUMBER
	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	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

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

On June 14, 1989, at 1740, with Unit 1 in Mode 1 at 100% power, a routine weekly valve status check was performed in accordance with a plant procedure which requires a valve position check of various emergency diesel system valves. While performing this valve status check, the 1B diesel fuel oil transfer pump discharge valve was found in the locked closed position. Although the 1B diesel was capable of starting and supplying post-accident loads during the event, it was administratively rendered out of service due to the inoperability of the 1B diesel fuel oil transfer pump, per Technical Specification 3.8.1.1.b.3. The most probable root cause of the mispositioned valve was personnel error by a utility non-licensed operator, though the responsible individual has not been identified. A contributing factor was the failure to record the mispositioned valve in the valve deviation log.

Corrective actions included re-opening and locking open the valve, and counseling the operators on the importance of, and the use of, the valve deviation log.

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

TEXT (If more space is required, use additional NRC Form 368A's) (17)

DESCRIPTION OF THE EVENT

On June 14, 1989, at 1740, with Unit 1 in Mode 1 at 100% power, a routine weekly emergency diesel system valve status check was performed by a utility non-licensed operator in accordance with Administrative Procedure 1-0010125A. While performing this valve status check, the 1B diesel fuel oil transfer pump discharge valve (E11S:ISV) was found in the locked closed position. This administratively rendered the 1B diesel generator out of service, per Technical Specification 3.8.1.1.b.3. The valve was unlocked, re-opened, locked open, and independently verified locked open, within 5 minutes of finding it closed.

Prior to this event, the last time the pump discharge valve was operated was at 1015 on June 5, 1989, to place the 1B diesel fuel oil tank on recirculation. This was required for a chemistry sample of the 1B diesel fuel oil tank. Although the valve was re-opened and locked open after the sample was completed, the closing and re-opening of the valve was not recorded in the Valve Deviation Log in accordance with Administrative Procedure 1-0010123.

The valve's locked open position was verified independently on June 7 by a utility non-licensed operator, and on June 13 by a QC Inspector, when the valve status check of Administrative Procedure 1-0020235A was performed.

On June 14, 1989, the valve was found in the locked closed position.

CAUSE OF THE EVENT

No fuel oil samples were taken and no maintenance was performed on the diesel fuel oil system between 1600 on June 13, 1989 and 1740 on June 14, 1989. Only Operations Department personnel have access to the valve locking device key. Therefore, the most probable root cause of the event was personnel error by a utility non-licensed operator. After investigation, the responsible individual has not been identified. A contributing factor to the event was the failure to record the repositioning of the valve in the Valve Deviation Log.

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		- 0 0 2	- 0 0	0 3	OF	0 3	

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

ANALYSIS OF THE EVENT

This event has been deemed reportable per the requirements of 10 CFR 50.73(a)(2)(i)(B), any operation or condition prohibited by the plant's Technical Specifications. Since the 1B Diesel was administratively out of service for as long as 25 hours, the surveillance requirements of Technical Specification 3.8.1.1., which requires that the operability of the other Diesel be tested within 1 hour and every 8 hours thereafter, should have been performed. However, this surveillance was not done because the operators were not aware of the out of service diesel.

Each emergency diesel is designed for full post-accident load operation for 75 minutes on the day tanks. The fuel oil transfer pump starts and the inlet valve to the day tanks opens at a day tank level of 23 inches. With the fuel oil transfer pump discharge valve shut, the diesel generator would start if required. However, automatic makeup to the day tank would be prevented, and the day tank level would decrease. Approximately 39 minutes later, at a level of 11 inches in the day tank, the low level annunciator would alert the operators of the problem locally and in the control room. This would leave approximately 36 minutes to dispatch an operator to the area to locate, unlock, and re-open the pump discharge valve.

Since the emergency diesel was available to perform its safety function, the health and safety of the public were not affected by this event.

CORRECTIVE ACTIONS

- 1) Operations personnel re-opened and locked open the valve.
- 2) The Operations Supervisor counselled the operators on the importance of, and the use of, the valve deviation log.

ADDITIONAL INFORMATION

1. COMPONENT IDENTIFICATION

This event was not caused by component failure.

2. PREVIOUS SIMILAR EVENTS

For a similar event, see LER #335-82-48, which pertains to the inoperability of the 1A diesel fuel oil pump due to valve mispositioning because of improper restoration from maintenance.