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ACCESSION NBR: 8911010026 **DOC.DATE:** 89/10/24 **NOTARIZED:** NO **DOCKET #**
FACIL: 50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co. 05000389
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RECIP.NAME **RECIPIENT AFFILIATION**

SUBJECT: LER 89-008-00: on 890924, Tech Spec surveillances performed improperly due to personnel error.

W/8 ltr.

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OCTOBER 24 1989

L-89-382
10 CFR 50.73

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

Gentlemen:

Re: St. Lucie Unit 2
Docket No. 50-389
Reportable Event: 89-08
Date of Event: September 24, 1989
Technical Specification Surveillance
Performed Improperly 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,

DA Sager
D. A. Sager
Vice President
St. Lucie Plant

DAS/JRH/gmp

Attachment

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

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PDR ADUCK 05000389
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) ST. LUCIE, UNIT 2	DOCKET NUMBER (2) 0 5 0 0 0 3 8 9	PAGE (3) 1 OF 0 4
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TITLE (4)
TECHNICAL SPECIFICATION SURVEILLANCES PERFORMED IMPROPERLY DUE TO PERSONNEL ERROR

EVENT DATE (6)			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)
09	24	89	89	008	00	10	24	89	N/A		05000

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

OPERATING MODE (9)	20.402(b)	20.406(e)	60.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 0 0 0	20.406(a)(1)(i)	60.38(c)(1)	60.73(a)(2)(v)	73.71(c)
	20.406(a)(1)(ii)	60.38(c)(2)	60.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.406(a)(1)(iii)	X 60.73(a)(2)(i)	60.73(a)(2)(viii)(A)	
	20.406(a)(1)(iv)	60.73(a)(2)(ii)	60.73(a)(2)(viii)(B)	
	20.406(a)(1)(v)	60.73(a)(2)(iii)	60.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME MICHAEL J. SNYDER, 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)

On September 23, 1989, St. Lucie Unit 2 was in Mode 3 following a manual reactor trip. At 1100 hours, Operators filled two Safety Injection Tanks (SIT). This requires that specific check valves in the Safety Injection Headers be tested to verify their closure within 24 hours and their leakage measured within 31 days. On September 24, 1989, at 0930, a Plant Engineer failed to follow approved plant procedures and performed an improper surveillance on the Safety Injection Header check valves to verify their closure. On September 25, 1989, a supervisor determined that the method could not provide verification of closure of these valves. These Safety Injection Header check valves subsequently passed their leak tests at 1245 on September 25, 1989. Further review indicated that on May 7, 1989, while St. Lucie Unit 2 was at 85% power, the filling of a SIT required the two check valves to be tested within 24 hours. However, due to a miscommunication, a Utility Engineer only tested one of the two check valves within the required period for valve closure verification. The valve was later tested satisfactorily on June 2, 1989. The cause of both events was personnel error by Utility Engineers. Corrective actions were to properly test the check valves involved and to counsel personnel involved on the importance of following approved procedures.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

DESCRIPTION OF EVENT:

On September 23, 1989, St. Lucie Unit 2 was in Mode 3 following a manual reactor trip. At 1100 hours, Operators filled the 2A1 and 2A2 Safety Injection Tanks (SIT) (EIIS:BP), and notified the Shift Technical Advisor (STA) that a test was required on the associated Safety Injection (SI) Header check valves (EIIS:BP). On September 24, 1989, at 0930, the STA failed to follow approved plant test procedures and recorded a constant differential pressure across the 2A1 and 2A2 SI Header check valves to verify their closure. Test personnel were then notified that a leak test would be required of these valves within the next 30 days. A supervisor reviewed the results of this verification method, and determined that the use of installed equipment did not provide verification of closure for these valves. These SI Header check valves later passed their leak tests at 1245 on September 25, 1989.

Subsequent review of previous SI check valve surveillances revealed that on May 7, 1989, while St. Lucie Unit 2 was in Mode 1 at 85% power during unit startup operations, operators filled the 2A1 SIT. During the fill process, the 2A2 SI Header was pressurized. The STA notified the Test Group verbally and on a surveillance turnover checklist that check valves in the 2A1 and 2A2 SI header required a surveillance. However, a Test Engineer misunderstood these communications and a test by approved procedures was only performed on the 2A1 SI Header check valve within the 24 hour period. The STA noted this discrepancy and the 2A2 SI header was leak tested satisfactorily on June 2, 1989.

CAUSE OF THE EVENT:

The cause of the missed surveillance on May 7, 1989, was due to a personnel error by a utility Test Engineer who misunderstood communications. The cause of the improper surveillance on September 24, 1989, was due to a personnel error by a utility STA in failing to follow an approved procedure. An approved plant procedure specifies the steps to properly perform a verification of Safety Injection check valve integrity. There were no unusual characteristics of the work location that contributed to the personnel errors.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

ANALYSIS OF EVENT:

This event is reportable under the requirements of 10 CFR 50.73(a)(2)(i)(B), as an operation or condition prohibited by St. Lucie Plant Technical Specifications.

St. Lucie Unit Two Technical Specification 3/4 4.6.2 requires that while operating in Modes 1, 2, 3, and 4, following Safety Injection check valve actuation due to flow through the valve: i) valve closure will be verified within 24 hours, and ii) the valve's leakage will be verified to be in tolerance within 31 days.

i) In both events, surveillances were performed, however, the portion for verifying valve closure was later determined to have been improperly performed. Failure to perform a surveillance requires compliance with the associated ACTION statement. In this instance, the ACTION statement requires that the high pressure portion of the system be isolated from the low pressure portion of the system within four hours by use of at least two closed manual or deactivated automatic valves. In both cases, three check valves in series separate the high and low pressure portions of the Safety Injection System to the Reactor Coolant System. Conservatively assuming that the check valve under surveillance was leaking still left two other check valves to serve as a pressure isolation boundary. Monitoring of installed pressure instruments will confirm the integrity of two of these three check valves. However, the St. Lucie Unit 2 ACTION statement only permits taking credit for check valves located inside containment as automatic valves for use as an RCS pressure boundary. Since one of these Safety Injection Header check valves is outside of containment, the ACTION statement was not satisfied.

ii) A satisfactory leak test for the check valves was obtained within 26 days for the event on May 7, 1989, and within two days for the second event on September 23, 1989. Both of these periods are within the 31 days allowed by Technical Specifications for leak testing. Successful completion of these tests confirmed that the valves were capable of performing their function as a pressure boundary.

Based on the above, it can be concluded that the health and safety of the public were not affected at any time with the improperly performed surveillances for verifying Safety Injection check valve seating.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

CORRECTIVE ACTIONS:

- 1) In both cases, satisfactory leak tests were performed on the Safety Injection check valves within the 31 day limit.
- 2) Personnel involved in the events were counselled on the importance of compliance with approved plant procedures.
- 3) A letter was issued to all Technical Staff personnel on the importance of compliance with approved plant procedures.
- 4) The surveillance turnover checklist was revised to clarify the required testing.

ADDITIONAL INFORMATION:

COMPONENT FAILURES

None

PREVIOUS SIMILAR EVENTS

The most recent similar event is LER 389-88-004, which describes a missed surveillance for the sampling of Iodine following a power change of >15% in one hour.