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FACIL:50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co. 05000389

AUTH.NAME	AUTHOR AFFILIATION
WOLAVER,M.W.	Florida Power & Light Co.
SAGER,D.A.	Florida Power & Light Co.
RECIP.NAME	RECIPIENT AFFILIATION

SUBJECT: LER 90-004-00:on 901109,inadvertent actuation of assorted engineered safeguards equipment,including emergency diesel generator 2A,occurred.Caused by personnel error.Personnel counseled.W/901210 ltr.

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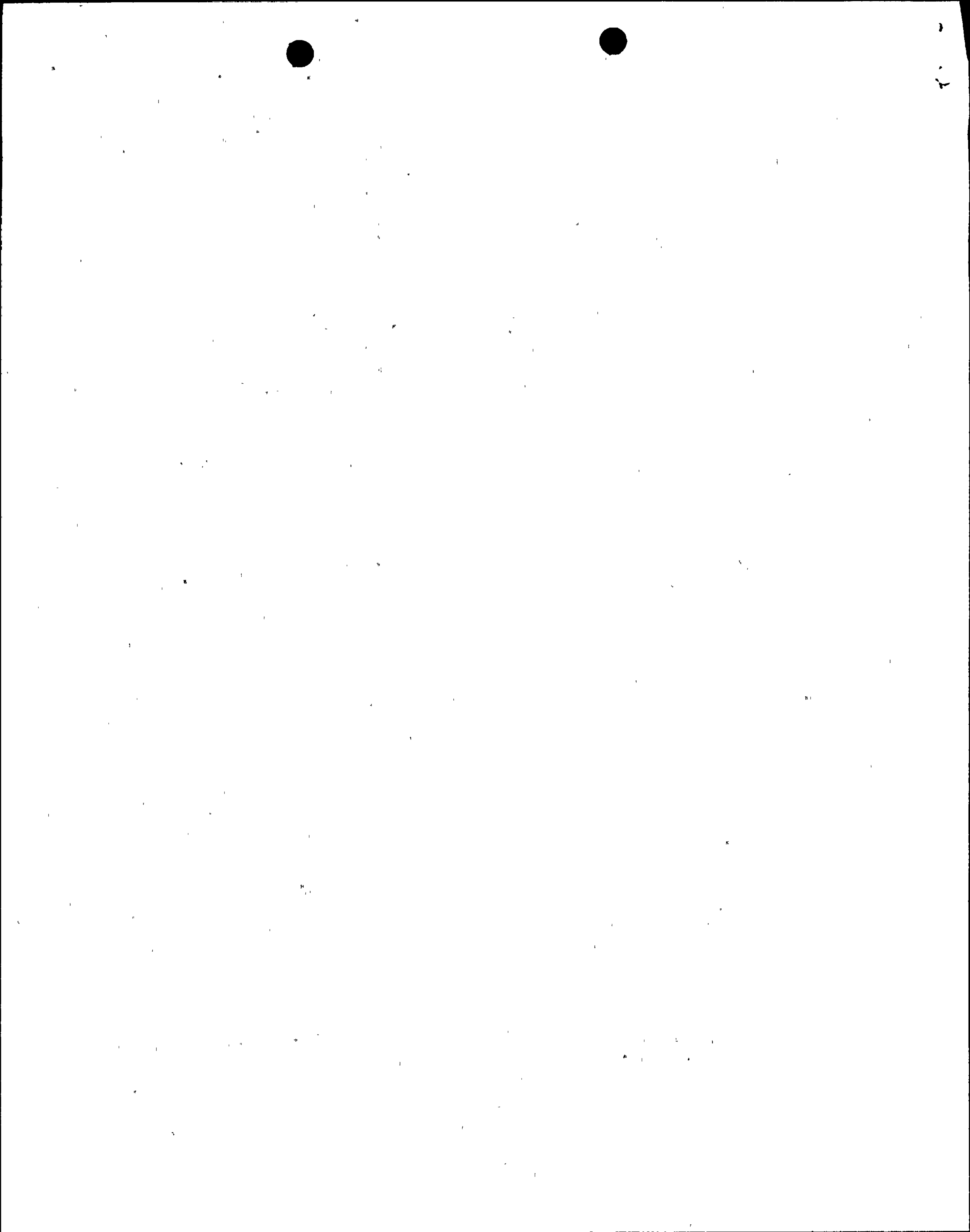


P.O. Box 14000, Juno Beach, FL 33408-0420

December 10, 1990

L-90-428
10 CFR 50.73

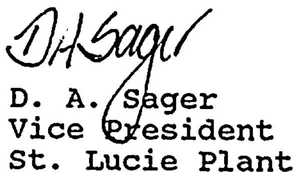
U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Gentlemen:

Re: St. Lucie Unit 2
Docket No. 50-389
Reportable Event: 90-04
Date of Event: November 9, 1990
Inadvertent Actuation of Engineered Safeguards Equipment
During Time Response Testing 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,



D. A. Sager
Vice President
St. Lucie Plant

DAS:GRM:kw

Attachment

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

DAS/PSL #297

9012170237 901210
PDR ADOCK 05000389
S PDR

IE22

FPL Facsimile of NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
St. Lucie Unit 2	0 5 0 0 0 3 8 9	1 OF 0 3

TITLE (4) INADVERTENT ACTUATION OF ENGINEERED SAFEGUARDS EQUIPMENT DURING TIME RESPONSE TESTING 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)
1 1	0 9	9 0	9 0	0 0 4	0 0	1 2	1 0	9 0	N/A	0 5 0 0 0

OPERATING MODE (9): 5

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)

	20.402(b)		20.405(c)	X	50.73(a)(2)(iv)		73.71(b)
	20.405(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)(vii)		OTHER *(Specify in Abstract below and in Text NRC Form 366A)*
	20.405(a)(1)(iii)		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)		
	20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (AREA CODE)
M. W. Wolaver, Shift Technical Advisor	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)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES *(If yes, complete EXPECTED SUBMISSION DATE)*	X NO				

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

On November 9, with Unit 2 in Mode 5 during a refueling outage, an inadvertent actuation of assorted Engineered Safeguards equipment, including the 2A Emergency Diesel Generator, occurred during Engineered Safeguards Features testing. This equipment belongs specifically to the 'A' side Safety Injection Actuation System/Containment Isolation Actuation System (SIAS/CIAS), Group 5.

The root cause of the event was personnel error. Instrumentation and Control personnel misread information in the testing procedure, and inadvertently actuated the wrong equipment.

Corrective actions: The test procedure was reviewed for errors. The testing was completed satisfactorily following this procedure. A Control Room Engineering Design Integration team reviewed color coding, placement and design of equipment labeling; workspace location and the procedure involved. No deficiencies were noted with respect to the criteria of NUREG 0700. An independent INPO Human Performance Enhancement System review was also performed on this event. The Instrument and Control personnel involved were counseled.

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

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

DESCRIPTION OF THE EVENT

On November 9, Unit 2 was in Mode 5 during a refueling outage. The Reactor Coolant System (RCS) (EIIS:AB) loops were full and on solid pressure control, with venting in progress. Instrument and Control (I&C) personnel were performing Engineered Safeguards (EIIS:JE) time response testing as per I&C procedure 2-1400053. According to the procedure, the Operations crew were briefed and given a list of equipment that were expected to actuate during that portion of the testing. The equipment listed belonged to the 'A' side Safety Injection Actuation Signal/Containment Isolation Signal (SIAS/CIAS) (EIIS:JM), Group 3. However, at 1959 hours, I&C personnel depressed the wrong pushbutton and unexpectedly actuated a different group of Engineered Safeguards equipment, the Group 5 equipment. The Operations crew immediately realized that the actuations were incorrect and notified the I&C personnel, then proceeded immediately to review Plant conditions and realign equipment. The major equipment that actuated included: 2A Emergency Diesel Generator (EIIS:EK), 2A Intake Cooling Water Pump, 2A Component Cooling Water Pump (EIIS:CC), 2A and 2B Boric Acid Makeup Pumps (EIIS:CA), and the Emergency Borate Valve. Testing was terminated, the Engineered Safeguards actuations were reset, and Mode 5 operations were resumed.

CAUSE OF THE EVENT

A Control Room Engineering Design Integration Team reviewed color coding, placement, labeling, workspace location, and the procedure involved. No deficiencies were noted with respect to the criteria of NUREG 0700. An independent INPO Human Performance Enhancement System (HPES) review was also performed on this event.

The root cause of this event was cognitive personnel error. Utility I&C personnel misread a correct and approved I&C testing procedure. The wrong pushbutton was depressed on an Engineered Safeguards cabinet actuation module. This caused the actuation of a different group of Engineered Safeguards equipment than anticipated. There were no adverse conditions at the work location that affected the job, and the pushbuttons were clearly and logically labeled.

ANALYSIS OF THE EVENT

This event is reportable under the requirements of 10CFR50.73.a.2.iv as an event that resulted in manual or automatic actuation of any Engineered Safeguards Feature.

The portion of the testing being performed at this time concerned the actuation of 'A' side SIAS/CIAS, Group 3 equipment. As a result of the error, Group 5 equipment was actuated. The Unit was configured in Mode 5 such that these actuations had no affect on Plant operation. All Group 5 equipment actuated correctly and properly as called upon. Therefore, there were no equipment operability concerns.

There is no possibility that this scenario could effect power operations due to the fact that this test is performed only in modes 3, 4, 5, or 6.

Thus, the health and safety of the public were not at risk at any time during this event.

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

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

CORRECTIVE ACTIONS

1. An HPES review was performed on this event.

2. A Control Room Engineering Design Integration Team review was performed on equipment, procedures, and work environment. No deficiencies with respect to NUREG 0700 were noted.

3. The Engineered Safeguards time delay testing was completed satisfactorily.

4. I&C personnel were counseled as to the need to follow test procedures closely.

ADDITIONAL INFORMATION

Failed Component Identification:

NONE

Previous Similar Events:

LER 389-89-003 describes an inadvertent Containment Isolation actuation due to a Licensed Operator mistakenly resetting one channel while a second channel was in the tripped condition.