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REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9110300224 DOC. DATE: 91/10/21 NOTARIZED: NO DOCKET #
 FACIL: 50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co. 05000389
 AUTH. NAME AUTHOR AFFILIATION
 LAUVER, C. Florida Power & Light Co.
 SAGER, D.A. Florida Power & Light Co.
 RECIPIENT NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-005-00: on 910924, discovered that Sept surveillance for safety injection tank water level & monthly channel functional test not performed on due date of 910920. Caused by personnel error. Test performed. W/911021 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

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	AEOD/DOA	1			1	AEOD/DSP/TPAB	1			1
	AEOD/ROAB/DSP	2			2	NRR/DET/ECMB 9H	1			1
	NRR/DET/EMEB 7E	1			1	NRR/DLPQ/LHFB10	1			1
	NRR/DLPQ/LPEB10	1			1	NRR/DOEA/OEAB	1			1
	NRR/DREP/PRPB11	2			2	NRR/DST/SELB 8D	1			1
	NRR/DST/SICB8H3	1			1	NRR/DST/SPLB8D1	1			1
	NRR/DST/SRXB 8E	1			1	<u>REG FILE</u> 02	1			1
	RES/DSIR/EIB	1			1	RGN2 FILE 01	1			1
EXTERNAL:	EG&G BRYCE, J.H	3			3	L ST LOBBY WARD	1			1
	NRC PDR	1			1	NSIC MURPHY, G.A	1			1
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OCT 21 1991

L-91-271
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: 91-05
Date of Event: September 24, 1991
Missed Surveillance for Safety Injection Tank Water Level and
Pressure Channel Functional Test 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,

A handwritten signature in dark ink, appearing to read "D. A. Sager", is written over the typed name.

D. A. Sager
Vice President
St. Lucie Plant

DAS/JJB/kw

Attachment

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

DAS/PSL #535-91

9110300224 911021
PDR ADOCK 05000389
S PDR

JEZ

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN FOR RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.8 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-330), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545, AND TO THE PAPERWORK REDUCTION PROJECT, 3150-0104, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) St. Lucie Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 8 9	PAGE (3) 1 OF 0 3
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TITLE (4) Missed Surveillance for Safety Injection Tank Water Level and Pressure Channel Functional Test 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 9	2 0	9 1	9 1	0 0 5	0 0	1 0	2 1	9 1	N/A		0 1 5 0 0 0 0 1 1 1		
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)
	20.405(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)	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)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Catherine Lauver, Shift Technical Advisor	TELEPHONE NUMBER AREA CODE 4 0 7 4 6 5 - 3 5 5 0
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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 24, 1991, it was discovered that the September surveillance for the Safety Injection Tank (SIT) water level and pressure monthly channel functional test was not performed when scheduled. Using the 25% maximum allowable extension permitted by Specification 4.0.2, the latest date for the monthly surveillance to be performed on time was September 20, 1991.

The root cause of the event was personnel error by the responsible Instrument and Control (I&C) system supervisor. Per I&C procedure, it is the responsibility of the cognizant system supervisor to ensure scheduling requirements are met. A contributing factor is that the I&C procedure for scheduling and performing work contained a requirement for an internal check by Planning to check with the system supervisor to ensure surveillances are performed but no mechanism existed to routinely satisfy this.

Corrective Actions were to perform the surveillance, counsel the system supervisor involved, and enhance the I&C scheduled surveillance procedure to ensure the Lead Supervisors verify surveillances have been performed.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST:
58.8 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS
MANAGEMENT BRANCH (P-336), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555,
AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET,
WASHINGTON, DC 20503.

FACILITY NAME (1) St. Lucie Unit 2	DOCKET NUMBER (2) 05000389	LER NUMBER (6)			PAGE (3)	
		YEAR 91	SEQUENTIAL NUMBER 005	REVISION NUMBER --00	02	OF 03

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

DESCRIPTION OF THE EVENT

At the beginning of each month, the Instrument and Control (I&C) Planning group schedules the surveillances required for the month and issues work packages to the responsible system supervisors. The surveillance for the Safety Injection Tanks (SIT)(EHS:BP) water level and pressure monthly Channel Functional Test was last performed August 12, 1991, and was scheduled to be performed September 9. The I&C system supervisor responsible for the surveillance was out of the office for several days at this time and the surveillance was not performed as scheduled. Upon returning to work, he did not realize the surveillance had not yet been performed. On September 24, a Quality Control inspector who was trying to verify completion of the surveillance discovered it had not been performed.

CAUSE OF THE EVENT

The cause of the event is cognizant personnel error by a utility I&C system supervisor contrary to approved plant procedure. I&C procedure 1400190, "I&C Department Surveillance/Testing Schedule," requires the cognizant system supervisor to ensure scheduling requirements have been met. There were no unusual characteristics of the work location that contributed to the error.

A contributing factor is that the independent check required by the I&C department procedure for performing surveillances was not performed. Each month, I&C Planning issues the work packages of surveillances required by Technical Specifications that are scheduled for the month to the responsible system supervisors. This process placed responsibility on the individual system supervisors and made no provisions for unexpected absence or inadvertent omission. The I&C procedure contained a requirement for Planning to confer with the system supervisor as necessary, but no formal method existed for routinely ensuring work was performed when scheduled or within the permissible time period.

CORRECTIVE ACTIONS

- 1) The Channel Functional Test was successfully performed September 24, 1991.
- 2) The event and importance of performing surveillances on time was discussed with the I&C system supervisor involved.
- 3) The I&C monthly Technical Specification surveillance sheet contained in I&C procedure 1400190, "I&C Department Surveillance/Testing Schedule," was modified to add a Completion Verified section, which will be initialed and dated by the system supervisor. This schedule will be reviewed daily by the lead supervisor.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION
REQUEST: 34.8 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE
RECORDS AND REPORTS MANAGEMENT BRANCH (F-335), U.S. NUCLEAR REGULATORY
COMMISSION, WASHINGTON, DC 20545, AND TO THE PAPERWORK REDUCTION PROJECT (3150-
0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) St. Lucie Unit 2	DOCKET NUMBER (2) 05000389	LER NUMBER (6)		PAGE (3)	
		YEAR 91	SEQUENTIAL NUMBER 005	REVISION NUMBER 00	03 OF 03

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

ANALYSIS OF THE EVENT

Technical Specification 4.0.3 states that a failure to perform a surveillance requirement within the allowable interval, defined by Specification 4.0.2, shall constitute noncompliance with the OPERABILITY requirements for a Limiting Condition for Operation. This event is reportable under 10 CFR 50.73.a.2.i.B, any operation or condition prohibited by Technical Specifications.

Technical Specification 4.5.1.2.a states each Safety Injection Tank water level and pressure channel shall be demonstrated OPERABLE at least once per 31 days by the performance of a CHANNEL FUNCTIONAL TEST. The required date was September 12, 1991. Technical Specification 4.0.2 permits a 25% maximum allowable extension, to September 20. The surveillance was satisfactorily performed on September 24. Periodic Channel Checks are required and were performed every four hours during the missed surveillance interval.

Section 6.3.2.2.1 of the Final Updated Safety Analysis Report states that the Safety Injection Tanks automatically discharge into the Reactor Coolant System if Reactor Coolant System pressure decreases below Safety Injection Tank pressure during reactor operation. The system is passive; the water level and pressure channels have no control functions. Therefore, the Safety Injection Tanks were capable of performing their intended safety function at all times between September 12 and September 24, 1991.

ADDITIONAL INFORMATION

Component Failures:

There were no component failures involved in this event.

Previous Licensee Event Reports concerning Missed Surveillances Due to I&C Personnel Error:

389-90-003 Missed Surveillance on Radiation Monitor Returned to Service Due to Personnel Error

389-86-003 Tardy Surveillance of Auxiliary Feedwater Logic due to Personnel Error

389-86-005 Missed Surveillance of Safeguards Actuation System Relays