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FACIL:50-335 St. Lucie Plant, Unit 1, Florida Power & Light Co. 05000335
AUTH.NAME AUTHOR AFFILIATION
SNYDER,M.J. Florida Power & Light Co.
SAGER,D.A. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 92-001-00:on 920117,fuel handling bldg ventillation stack radiation monotor was not in svc during routine check. Caused by personnel oversight.Event was reviwed w/chemistry personnel.W/920218 ltr.

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P.O. Box 128, Ft. Pierce, FL 34954-0128

February 18, 1992

L-92-37
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: 92-01
Date of Event: January 16, 1992
Fuel Handling Building Ventilation Radiation Monitor
Out of Service 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/JJB/kw

Attachment

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

DAS/PSL #621-92

IE22
1/1

FPL Facsimile of NRC Form 366 (8-89)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
St. Lucie Unit 1	0 5 0 0 0 3 3 5	1 OF 0 4

TITLE (4) Fuel Handling Building ventilation radiation monitor out of service results in a condition prohibited by Technical Specifications due to a 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 1	1 6	9 2	9 2	0 0 1	0 0	0 2	1 8	9 2	N/A	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		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	TELEPHONE NUMBER
Michael J. Snyder, Shift Technical Advisor	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	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	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 17 January, 1992 at 0730, a plant Chemistry supervisor noted that the Unit 1 Fuel Handling Building (FHB) ventilation stack radiation monitor was not in service during a routine check of that system's operability. This FHB monitor is required to be in service by plant Technical Specifications, or else to have in place alternate means of sampling and monitoring the FHB ventilation effluent. A review of this event indicated that the radiation monitor was probably placed out of service during routine grab sampling of the FHB effluent at 0830 on 16 January. By procedure, the radiation monitor's sample pump is secured during grab sampling and should be restarted following sampling completion.

The root cause of this event is attributed to an oversight by Chemistry personnel for not restarting the FHB stack radiation monitor sample pump. A contributing factor to this event is that the sample pump's low flow alarm was improperly overridden during the grab sample surveillance. Another contributing factor is that Operations personnel who found the sample pump secured during the midnight shift equipment checks on January 17th did not contact Chemistry personnel and improperly restarted the monitor.

During the 23 hour period that the monitor was out of service, there were no work activities taking place in the FHB, and subsequently no unplanned effluent releases through the FHB ventilation stack were made. Corrective actions for this event: Properly restored the FHB stack radiation monitor to service, Chemistry supervision has reviewed this event with all Chemistry personnel to discuss the importance of following procedures and not adjusting alarm setpoints unless procedurally addressed, Operations supervision has emphasized the need for notifying Chemistry when problems occur with effluent radiation monitors, Training will evaluate this event for use in plant personnel training.

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

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

DESCRIPTION OF THE EVENT

On 16 January, 1992, St. Lucie Unit 1 was in Mode 1 at 100% power. At 0830, a Technical Specification required grab sample was drawn from the Fuel Handling Building (FHB) ventilation stack radiation monitor (EIIS:IL) by a utility Chemistry technician. Per an approved plant procedure, the radiation monitor's sample pump is secured during this surveillance. Before the sample was taken, the technician overrode the radiation monitor's low flow alarm in order to avoid spurious alarms in the control room. Override of the alarm is not an approved practice.

On 17 January, during midshift while making his required equipment checks, a non-licensed operator noted that the FHB stack monitor sample pump was secured. The monitor flow indicated zero flow and the sample pump was off, but power was still available to the monitor skid. He notified the control room of this condition, and with the concurrence of licensed operators he restarted the sample pump. Nominal sample flow through the monitor was noted, no abnormal alarms were noted in the control room, and operators assumed that the monitor was back in service.

At 0730, a routine system check of the FHB monitor by a Chemistry supervisor reviewing the printout history of effluent monitors revealed that the FHB vent radiation monitor had been in the ' purge' mode since 0134 hrs on the 17th, and was therefore inoperable. Operators in the control room were notified, and the system was restored to service at 0805.

CAUSE OF EVENT

The root cause of the FHB vent radiation monitor being found secured is attributed to the Chemistry technician inadvertantly failing to restart the sample pump after taking the weekly grab sample on the 16th. Procedurally, the sample pump is to be secured while drawing the grab sample, and then restarted upon completion of the surveillance. The cause of the monitor being put in the purge condition at 0134 on the 17th is most likely due to improperly restarting the monitor by Operations personnel. Functional equipment checks by Operations and Chemistry personnel after this event did not reveal any mechanical or electrical faults which may have caused the system to inadvertantly run in the purge mode of operation.

There were several contributing factors to this event. One contributing factor was that the sample pump's low flow alarm was overridden during the surveillance, and was not restored after the grab sample was drawn due to an oversight. This is not an approved practice. The low flow alarm annunciates in the control room, and would have alerted operators of low radiation monitor sample flow. A second contributing factor to this event was that Operations personnel did not notify the on shift Chemistry technician that the FHB vent radiation monitor was found to be out of service. This action may have shortened the time the monitor was out of service. A third contributing factor to this event is that the shiftly data taken on this process monitor showed normal trends, and did not identify any trends or problems with the FHB vent radiation monitor. This condition is expected because the FHB is normally at background radiation levels, and background radiation levels are also recorded when the monitor's sample pump is secured or in the purge mode of operation. There were no unusual work characteristics or adverse environmental conditions which contributed to this event.

ANALYSIS OF EVENT

This event is reportable under 10 CFR 50.73.a.2.i. as "any operation or condition prohibited by the plant Technical Specifications.". As per Technical Specification 3.3.3.10, the required action to be taken with the FHB vent radiation monitor inoperable is to immediately suspend the release of effluents monitored by the instrument or else estimate effluent release rate and take grab samples every 8 hours and provide for continuous sampling with auxiliary sample equipment. The function of the effluent radiation monitor is to provide indication of radiation levels during normal and accident conditions.

In this event, the FHB vent radiation monitor was out of service for approximately 23 hours. During that period, the FHB exhaust fan was in operation, but no work was being performed in the FHB. Therefore, there was no unplanned release from the FHB during that time period. In the unlikely event that an unplanned release from the FHB vent had occurred during the time period that the effluent radiation monitor was out of service, operators would have been alerted to this condition by an increasing trend in shiftly logs readings of the FHB area radiation monitors. These independent area monitors also have alarms which sound in the control room. Therefore, the health and safety of the public was not affected by this event.

CORRECTIVE ACTIONS

1. Operations and Chemistry personnel restored the FHB vent radiation monitor back to service.

2. Functional testing of the FHB vent monitor done by Operations and Chemistry personnel did not reveal any mechanical or electrical faults which may have caused the system to inadvertantly run in the 'purge' mode.

3. Chemistry supervision has reviewed this event with all Chemistry personnel to discuss the generic importance of procedural compliance and the importance of step by step execution of a procedure for an evolution.

4. Chemistry supervision has reviewed this event with all Chemistry personnel to discuss the generic importance of not adjusting alarm setpoints unless procedurally addressed.

5. Chemistry will revise the applicable procedure to caution against defeating alarm setpoints when this practice is not specfically called for.

6. Operations supervision has emphasized the need to notify Chemistry when problems occur with effluent radiation monitors.

7. Training will evaluate this event for use in plant staff training.

ADDITIONAL INFORMATION

Component Failures

None

Previous Similar Events

A prevous similar event is described in LER 335-89-006, when a Technical Specification effluent monitor was inoperable due to an I&C personnel error during maintenance.