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ACCESSION NBR: 9212010088 DOC. DATE: 92/11/24 NOTARIZED: NO DOCKET #
 FACIL: 50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co. 05000389
 AUTH. NAME AUTHOR AFFILIATION
 WACHTEL, P. Florida Power & Light Co.
 SAGER, D.A. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 92-007-00: on 921025, licensed operator inadvertently started 2B containment spray pump. Caused by cognitive personnel error. Plant training dept will evaluate event to determine appropriate training requirements. W/921124 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4
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P.O. Box 128, Ft. Pierce, FL 34954-0128

November 24, 1992

L-92-326

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

Re: St. Lucie Unit 2
Docket No. 50-389
Event: 92-007
Date of Event: October 25, 1992
Inadvertent Start of the
2B Containment Spray Pump

The attached Licensee Event Report is being submitted voluntarily to provide notification of the subject event.

Very truly yours,

D. A. Sager
Vice President
St. Lucie Plant

DAS/JWH/kw

Attachment

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

DAS/PSL #822-92

300150
9212010088 921124
PDR ADOCK 05000389
S. PDR

an FPL Group company

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 80.8 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-630), 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) Inadvertent Start of the 2B Containment Spray Pump 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	0	2 5 9 2	9 2	0 0 7	0 0	1	1	2 4 9 2	N/A	0 5 0 0 0 1 1	
									N/A	0 5 0 0 0 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)									
		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)						
POWER LEVEL (10)	1 0 0	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)	X	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 Patricia Wachtel, 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 October 25, 1992, St. Lucie Unit 2 was in mode 1 operating at 100% steady state power. At 2305, a licensed utility operator was performing a valve stroke time surveillance when he inadvertently started the 2B containment spray pump. No spray flow resulted from the pump start, which lasted approximately 0.8 seconds, because the flow control valve was closed.

The root cause of this event was cognitive personnel error. A licensed utility operator inadvertently turned the control switch for the 2B containment spray pump from the AUTO to the START position rather than STOP while removing that pump from service in preparation of a valve stroke time surveillance.

Corrective actions taken included: immediately placing the 2B containment spray pump control switch to the STOP position, counseling the individual involved on the importance of self-verification when performing any type of surveillance, revising the surveillance procedure to delete the step to place the containment spray pump control switch in the STOP position, and performing an INPO style Human Performance Enhancement System evaluation on this event. The Plant Training Department will evaluate this event to determine appropriate training requirements.

This Licensee Event Report is being submitted voluntarily. The spray line flow control valve was closed when the 2B containment spray pump was started. No Engineered Safety Feature logic circuitry was energized.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 30.8 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-333), 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) 0 5 0 0 0 3 8 9	LER NUMBER (6)			PAGE (3)		
		YEAR 9 2	SEQUENTIAL NUMBER - 0 0 7	REVISION NUMBER - 0 0			
0 2 OF 0 3							

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

DESCRIPTION OF EVENT

On October 25, 1992, St. Lucie Unit 2 was in mode 1 at 100% steady state power. A licensed utility reactor control operator (RCO) was performing a surveillance as per Administrative Procedure 2-00010125, Schedule of periodic Tests, Checks, and Calibrations. At 2305, after successfully completing the 2A containment spray (EISS:BE) header flow control valve stroke time surveillance, the RCO proceeded to surveil the 2B train of equipment. The procedure directs the RCO to turn the associated containment spray pump control switch from the AUTO to the STOP position prior to cycling the flow control valve. The RCO inadvertently turned the three position control switch for the 2B containment spray pump to the START rather than STOP position, thereby causing the pump to start. The RCO realized the error immediately and rotated the control switch to STOP. Because the spray line flow control valves were fully closed at this time, no spray flow resulted. The Sequence of Events Recorder (SOER) (EISS:IQ) indicated that the pump run time was 0.778 seconds.

After operators verified that no containment spray flow occurred, the flow control valve surveillance was completed satisfactorily. The 2B containment spray system was then restored to service.

CAUSE OF EVENT

The root cause of the event was cognitive personnel error by a licensed utility operator with procedural deficiency being a contributing factor. The surveillance procedure for cycling the containment spray header flow control valves directs the operator to place the associated containment spray pump's breaker control switch from the AUTO to STOP position prior to cycling the valve. It was during this step that the three position switch was rotated in the wrong direction to the START position. Inattention to detail by the RCO was the direct cause of this event.

Further evaluation of the surveillance procedure revealed that the step of placing the pump control switch from the AUTO to the STOP position contributed to the inadvertent start of the pump. This step was intended to minimize the possibility of an inadvertent spray into containment while stroking the header flow control valve. Procedurally requiring the containment spray pump to be removed from service was determined to be an unnecessary switch manipulation.

There were no unusual characteristics of the work location that directly contributed to this error.

ANALYSIS OF EVENT

This event is being reported voluntarily for informational purposes.

The containment spray header flow control valve was fully closed prior to starting the 2B containment spray pump and remained fully closed during the time that the SOER indicated that the pump was running. There was no initiation of spray flow into containment. Additionally, no Engineered Safety Feature logic circuitry was satisfied during this event.

The health and safety of the public were not affected by this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION
REQUEST: 30.3 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS
AND REPORTS MANAGEMENT BRANCH (P-503), U.S. NUCLEAR REGULATORY COMMISSION,
WASHINGTON, DC 20548, 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	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 2	0 0 7	0 0	0 3	OF	0 3

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

CORRECTIVE ACTIONS

1. The utility reactor control operator immediately secured the 2B containment spray pump.
2. The individual involved was counseled by Operations supervision on the importance of self-verification when performing surveillances.
3. The Training Department distributed a training bulletin containing a description of this event to all Licensed Operators. The existing Operations policy on self-checking was also included.
4. The procedures AP 1/2-0010125, Schedule of periodic Tests, Checks, and Calibrations, were revised by Operations. The steps which direct the RCO to place the containment spray pump control switch in the STOP position during stroke time testing of a containment spray header flow control valve have been deleted.
5. The Technical Staff reviewed other surveillances in AP 1/2-0010125 for generic consideration of unnecessarily removing a safety related pump from service when performing a surveillance. No other test conditions similar to the contributing factor described in this event were identified.
6. An INPO style Human Performance Enhancement System evaluation was performed on this event and its conclusions agree with this LER.
7. The Training Department will evaluate this event to determine appropriate training requirements.

ADDITIONAL INFORMATION

Component Failures

None

Previous Similar Events

For a similar event see LER 335-85-006.