

CATEGORY 1

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ACCESSION NBR:9610280157 DOC.DATE: 96/10/23 NOTARIZED: NO DOCKET #
FACIL:50-389 St. Lucie Plant, Unit 2, Florida Power & Light Co. 05000389
AUTH.NAME AUTHOR AFFILIATION
QUILLEN,P.T. Florida Power & Light Co.
STALL,J.A. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 96-004-00:on 960923,operation prohibited by TS occurred.
Caused by Cognitive personnel error.FPL verified that a
successful stroke time surveillance was conducted on
FCV-25-7 & FCV-25-8.W/961023 ltr.

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TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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Florida Power & Light Company, P.O. Box 128, Fort Pierce, FL 34954-0128

October 23, 1996

L-96-271
10 CFR 50.73

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

Re: St. Lucie Unit 2
Docket No. 50-389
Reportable Event: 96-004
Date of Event: September 23, 1996
Operation Prohibited by Technical Specifications due to
Missed Surveillance Caused by Cognitive Operator 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,

J. A. Stall
Vice President
St. Lucie Plant

JAS/PTQ

Attachment

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

IE221

9610280157 961023
PDR ADOCK 05000389
S PDR

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 60.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FEED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-8 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20566-0001, 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

PAGE (3)

1 OF 4

TITLE (4)

Operation Prohibited by Technical Specification due to Missed Surveillance caused by Cognitive 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 NAME	DOCKET NUMBER
09	23	96	96	004	00	10	23	96	N/A	N/A
<p>THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)</p>										
OPERATING MODE (9)	1	20.2201(b)		20.2203(a)(2)(v)		X		50.73(a)(2)(i)		50.73(a)(2)(viii)
POWER LEVEL (10)	100	20.2203(a)(1)		20.2203(a)(3)(i)				50.73(a)(2)(ii)		50.73(a)(2)(x)
		20.2203(a)(2)(i)		20.2203(a)(3)(ii)				50.73(a)(2)(iii)		73.71
		20.2203(a)(2)(ii)		20.2203(a)(4)				50.73(a)(2)(iv)		OTHER
		20.2203(a)(2)(iii)		50.38(c)(1)				50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 386A
		20.2203(a)(2)(iv)		50.38(c)(2)				50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME

Paul T. Quillen II, Licensing Analyst

TELEPHONE NUMBER (Include Area Code)

(561) 467-7161

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).

X

NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On September 23, 1996, St. Lucie Unit 2 was operating in Mode 1 at 100 percent power. During a review of surveillance records, utility non-licensed work control personnel discovered that a stroke time surveillance for two containment vacuum relief valves (FCV-25-7 and FCV-25-8) had not been performed as required by the quarterly surveillance schedule. Further investigation revealed that the valves were stroked and timed satisfactorily on May 15, 1996 and then again on September 20, 1996. This interval exceeded the required 92 day Technical Specification (TS) requirement and 25 percent allowable extension period by approximately 13 days. The missed surveillance was deferred under the belief that a timed stroke of the valves had been performed on June 9, 1996, during maintenance testing.

The cause of the event was cognitive personnel error on the part of utility non-licensed work control personnel who rescheduled the required quarterly surveillance for the containment vacuum relief valves without verifying the date of the last performed surveillance. Insufficient clarity of the Nuclear Plant Work Order (NPWO) instructions contributed to the error.

Corrective Actions: 1) FPL verified that a successful stroke time was conducted on September 20, 1996. 2) Work control personnel are reviewing previous surveillance data for the date last performed for any TS component that is placed on a deferred surveillance schedule. 3) The Administrative tracking sheet for TS deferred surveillances has been revised to require that the last surveillance performed be verified. 4) The Unit 1 and Unit 2 NPWO task descriptions for the semi-annual functional test of the pressure differential transmitters have been revised to state that stroke time is not required.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1) ST. LUCIE UNIT 2	DOCKET 05000389	LER NUMBER (6)			PAGE (3) 2 OF 4
		YEAR 96	SEQUENTIAL 004	REVISION 00	

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

DESCRIPTION OF THE EVENT

On September 23, 1996, St. Lucie Unit 2 was operating in Mode 1 at 100 percent power. While reviewing TS surveillance records for the Unit 2 containment to annulus vacuum relief valves (FCV 25-7 and FCV 25-8) (EIS:NH), a utility non-licensed technician discovered that a required stroke time surveillance for the two containment vacuum relief valves had not been performed as required by Operating Procedure (OP) 2-0010125A, Data Sheet (DS) 8A. A review of the records indicated that the valves were stroked and timed satisfactorily on May 15, 1996 and then again on September 20, 1996. The requirement for performing the stroke time surveillance for these valves is once every 92 days. The above interval exceeded that period and the allowable TS extension of 25 percent by approximately 13 days.

Background

On May 15, 1996, the quarterly surveillance of the containment vacuum relief valves was performed satisfactorily. The surveillance was then scheduled to be performed again by August 15, 1996, as part of the regular quarterly surveillance interval prescribed for these valves. On June 9, 1996, a scheduled semi-annual functional test of the pressure differential transmitters (PDTs) (PDT 25-1A, 1B, 13A, and 13B) (EIS:NH), which open the containment vacuum relief valves was performed. This test is performed under a Nuclear Plant Work Order (NPWO) which requires the vacuum relief valves to be opened using the pressure differential transmitters to ensure proper system operation. The vacuum relief valves were stroked on June 9, 1996, as part of the semi-annual test, however, a stroke time was not recorded as a part of the test since work had not been performed which would have affected valve stroke times.

On August 15, 1996, when the scheduled quarterly surveillance for the containment vacuum relief valves was again due to be performed, the surveillance was deferred and the upcoming semi-annual functional test of pressure differential transmitters was moved forward so that they could be done in conjunction. The pressure differential transmitters supply the containment vacuum relief valves with an "OPEN" signal at a pre-determined differential pressure. Work control personnel responsible for tracking TS surveillance compliance allowed the quarterly surveillance of the vacuum relief valves to be deferred so that it could be combined with the semi-annual functional test. This decision was based upon the knowledge that stroke time testing was routinely performed during the semi-annual functional test of the differential pressure transmitters for the containment vacuum relief valves (last performed on June 9, 1996). A check of quality records was not performed. The quarterly stroke time surveillance was subsequently completed on September 20, 1996, however, the required surveillance interval had been exceeded.

CAUSE OF THE EVENT

The event was caused by cognitive personnel error on the part of utility non-licensed work control personnel who believed that the stroke time surveillance test of the containment to annulus vacuum relief valves had been completed during the performance of a semi-annual functional test on the pressure differential transmitters. A check of the previous surveillance data was not performed to verify this belief. Additionally, the Nuclear Plant Work Order instructions for the semi-annual surveillance of the pressure differential transmitters did not clearly indicate that valve stroke time testing was not required. The stroke time testing had been conducted in the past during the performance of the semi-annual surveillance.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL	REVISION	
ST. LUCIE UNIT 2	05000389	96	- 004	- 00	3 OF 4

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

CAUSE OF THE EVENT Continued

Based on the belief that the stroke time test was conducted on June 9, 1996, the work control personnel allowed a regularly scheduled quarterly stroke time test of the valves to be rescheduled to a later date. As a result, the requirement to time the stroke of the vacuum relief valves was not met within the quarterly surveillance frequency.

ANALYSIS OF THE EVENT

This event is reportable under 10 CFR 50.73 (a) (2) (I) (B), as any operation or condition prohibited by the plant's Technical Specifications. St. Lucie Unit 2 TS 3.6.5, requires that the primary containment vessel to annulus vacuum relief valves shall be operable with an actuation set point of less than or equal to 9.85 plus or minus 0.35 inches water gauge while in Modes 1 through 4. As stated in TS 3.6.5 the operability of these valves ensures that the containment internal pressure differential does not become more negative than 0.615 psi.

The surveillance requirements associated with the containment vacuum relief valves are specified in St. Lucie Unit 2 TS 4.0.5. This TS requires that in service inspection and testing be completed in accordance with Section XI of the ASME Boiler and Pressure Vessel Code and applicable addenda for code class 1, 2 and 3 pumps and valves. The containment vacuum relief valves are class 2 valves and the implementing procedures for performing the TS testing of these valves requires stroke time testing once every 92 days. The failure to stroke time the valves per the required frequency, including allowable extension time, constitutes a condition prohibited by the plant's Technical Specifications.

The design basis event for which the containment vacuum relief valves were designed is the accidental initiation of the containment spray system (2 trains) while all four fan coolers are in operation and the containment is at the maximum normal operating temperature of 120 degrees Fahrenheit. There is no single failure which can initiate both containment spray trains. Initiation of containment spray is by coincidence of both a safety injection actuation signal (SIAS) and high-high containment pressure signal.

The St. Lucie Unit 2 Updated Final Safety Analysis Report (UFSAR) does not specify an active safety function or a maximum stroke time for the containment vacuum relief valves. These valves are normally closed, and fail closed upon the loss of instrument air. The safety function of these valves is to remain closed and provide a redundant containment isolation barrier for penetrations 67 and 68, during containment pressurization events. The valves are also designed to automatically open whenever a vacuum condition inside containment threatens containment vessel integrity. There are no radiological consequences associated with a containment vacuum event, however, protecting the containment vessel from vacuum induced loads is considered by the St. Lucie Design Basis Documents (DBD) to be a quality related function.

The containment vacuum relief valves were stroked and timed on September 20, 1996, approximately 13 days excess of the required surveillance interval. The stroke times for this surveillance were satisfactory.

Based on the above, the health and safety of the public were not affected by this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (8)			PAGE (3)
		YEAR	SEQUENTIAL	REVISION	
ST. LUCIE UNIT 2	05000389	96	-- 004	-- 00	4 OF 4

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

CORRECTIVE ACTIONS

- 1) FPL verified that a successful stroke time surveillance was conducted on FCV-25-7 and FCV-25-8 per OP-2-0010125A data sheet (DS) 8A on September 20, 1996.
- 2) FPL Work Control personnel are reviewing previous surveillance data to verify the date last performed for any TS component that is deferred beyond its scheduled due date. This action will provide a positive check of actual surveillance status upon which to base rescheduling dates.
- 3) The Administrative tracking sheet for TS deferred surveillances (OP-2-0010125A, data sheet (DS) 29), has been revised to require that the last surveillance date performed be verified to ensure surveillance frequencies are not exceeded.
- 4) The Unit 1 and Unit 2 NPWO task descriptions for the semi-annual functional test of the pressure differential transmitters for FCV-25-7 and FCV-25-8 have been revised to state that stroke time is not required.

ADDITIONAL INFORMATION

Failed Component Identification

There were no component failures involved in this event.

Previous Similar Occurrences

- LER 389-95-003 "Missed Technical Specification Scheduled Surveillance Due to Procedure Deficiency" This event describes a missed surveillance of the Containment Personnel Airlock due to a procedural deficiency related to scheduling.
- LER 389-93-001 "Missed Surveillance for Safety Injection Tank Sampling Due to Personnel Error" This event describes a personnel error by a chemistry technician to sample the 2A1 Safety Injection Tank (SIT).