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ACCESSION NBR:8908230410 DOC.DATE: 89/08/14 NOTARIZED: NO DOCKET #
 FACIL:50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
 AUTH.NAME AUTHOR AFFILIATION
 MOWREY,C. Florida Power & Light Co.
 WOODY,C.O. Florida Power & Light Co.
 RECIPI.NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-007-00:on 890713,missed visual exam on repaired
 containment penetrations due to personnel error.
 W/8 ltr.

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AUGUST 14 1989

L-89-279
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 4
Docket No. 50-251
Reportable Event: 89-07
Date of Event: July 13, 1989
Missed Visual Examination on Repaired Containment
Penetrations 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,

R. J. Acosta
for

C. O. Woody
Acting Senior Vice President - Nuclear

COW/JRH/cm

Attachment

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

8908230410 890814
PDR ADQCK 05000251
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Turkey Point Unit 4	DOCKET NUMBER (2) 0 5 0 0 0 2 5 1 1	PAGE (3) 1 1 OF 0 3
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TITLE (4) **Missed Visual Examination on Repaired Containment Penetrations 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)
07	13	89	89	007	0	08	14	89			0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9) **1**

POWER LEVEL (10) **0 2 5**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 50.38(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.38(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)
<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Craig Mowrey, Regulation and Compliance	TELEPHONE NUMBER
	AREA CODE: 3 0 5 NUMBER: 2 4 6 - 2 2 2 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 July 13, 1989, with Unit 4 at 25% power (Mode 1), it was determined that a required visual examination for leakage had been missed. Three containment isolation valves had been replaced, requiring a steam generator hydrostatic test. To allow delay to the next scheduled steam generator hydrostatic test, ASME Code Case N-416 was invoked, requiring a surface examination (NDE), and a visual examination for leakage after system pressurization. Since the testing was not completed immediately upon reaching conditions allowing it, the 3 associated containment penetrations were technically inoperable. The cause was cognitive personnel error in not performing the test immediately upon return to service of the repaired piping. Although the 3 penetrations were technically inoperable, no degradation of a safety barrier existed, as demonstrated by the satisfactory completion of the visual examination within one hour of discovery of the condition. The personnel involved have been counseled. Procedures and practices governing work and follow-on testing by construction are being reviewed to determine if changes can be made to aid in preventing recurrence.



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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Turkey Point Unit 4	DOCKET NUMBER (2) 0 5 0 0 0 2 5 1	LER NUMBER (8)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 9	- 0 0 7	- 0 0	0 2	OF	0 3

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

DESCRIPTION OF EVENT

On July 13, 1989, Unit 4 was in Mode 1 at approximately 25% power. At 1512 it was determined that a required visual examination for leakage had been missed. The missed test was discovered by the Construction project field engineer (non-licensed contractor), during his review of the open items on his punchlist. Three valves were replaced during the last refueling outage. These are two inch valves which tie the steam generators (EIIIS component SG) to the wet layup system, and are normally closed during plant operation. They also serve as containment isolation valves. Because these lines tie directly to the steam generators, the required hydrostatic test was delayed to the next regularly scheduled steam generator hydrostatic test. The delay was approved by invoking ASME code case N-416. This code case allows the delay provided two conditions are met; the new welds are examined using surface examination methods, and "prior to or immediately upon return to service, a visual examination (VT-2) for leakage shall be conducted...." The surface examination was conducted as required, but the visual examination was left open pending pressurization of the lines.

Technical Specification 3.3.1 requires that containment integrity be maintained in Modes 1 through 4. Since the testing was not completed immediately upon reaching conditions allowing performance of the system functional test, the three containment penetrations associated with these lines were technically inoperable, and containment integrity was not verified to be maintained. The associated action statement requires that containment integrity be restored within one hour. The required visual examinations were performed within one hour of discovery of the condition, and no leakage was detected.

CAUSE OF EVENT

The cause of the event was cognitive personnel error. The engineering package correctly invoked the code case, and required the two compensatory tests. The Mechanical Process Installation List (construction department work document) required the System Functional Test. When the system was released to the plant for use in filling the steam generators, the test was identified in the punchlist of incomplete items. The error was that the cognizant field engineer did not ensure that the test was performed immediately upon returning the repaired piping to service.

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

ANALYSIS OF EVENT

Although the three associated penetrations were technically inoperable, no degradation of a safety barrier existed. This was verified by performing the initial surface examination, and later demonstrated by the satisfactory completion of the visual examination. The penetrations were capable of performing their intended function. Based on the above, the health and safety of the public were not affected.

CORRECTIVE ACTIONS

- 1) The required visual examination was performed satisfactorily within one hour of discovery of the condition. No leakage was detected.
- 2) The cognizant field engineer and the construction supervisors have been counseled regarding the circumstances and significance of the incident.
- 3) Procedures and other documents governing the flow of work and testing by the construction department are being reviewed to determine if changes can be made to aid in preventing recurrence. The review will be completed and any beneficial procedure changes submitted for approval by October 14, 1989.

ADDITIONAL INFORMATION

No similar events have been reported.