

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <b>CRYSTAL RIVER UNIT 3</b>	DOCKET NUMBER (2) <b>0500003012</b>	PAGE (3) <b>1 OF 04</b>
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TITLE (4) **Personnel Error Results in Failure to Enter Action Statement for Containment Isolation Valve Stroke Time**

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	2	23	8	8	005	0	3	24	N/A		050000
0	2	23	8	8	005	0	3	24	N/A		050000

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

OPERATING MODE (9) <b>1</b>	<input type="checkbox"/> 20.402(a)	<input type="checkbox"/> 20.406(a)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
POWER LEVEL (10) <b>1, 0, 0</b>	<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 50.38(e)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(e)
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.38(e)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 306A)
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)	
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(vii)(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 <b>L. W. MOFFATT, NUCLEAR SAFETY SUPERVISOR</b>	TELEPHONE NUMBER AREA CODE: <b>904</b> NUMBER: <b>795-6486</b>
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

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 February 23, 1988, Crystal River Unit 3 was operating at steady state in MODE 1 (power operation). A time stroke surveillance on a containment isolation valve was being performed. It was determined that the stroke time was greater than the maximum allowable stroke time permitted by the Limiting Condition for Operation of plant Technical Specifications. At this time, the associated ACTION statement was not entered due to personnel error by the shift supervisory personnel. The error was discovered approximately three days later when data was being reviewed by the In-service Inspection Department. The appropriate ACTION was entered but the error resulted in the plant operating in a condition prohibited by Technical Specifications. The shift supervisory personnel involved were counselled on Technical Specification requirements of containment isolation valve stroke times. This event will be reviewed by all licensed operators.

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

EVENT DESCRIPTION

On February 23, 1988, Crystal River Unit 3 was operating at steady state in MODE 1 (power operation). The Decay Heat Removal [BP] system was not being utilized and all valves [V] in the pump [P] suction line (dropline) from the Reactor Coolant system [AB] were closed (see Figure 1). CR-3 Technical Specifications, Table 3.6-1, states that DHV-41, the outboard containment isolation valve [BD,ISV], has a maximum allowable stroke time of 120 seconds. On February 23, 1988, the control board licensed reactor operator performed the time stroke test on DHV-41 required by Surveillance Procedure SP-340A, 'A' Train ECCS Pump & Valve Operability. He then closed DHV-41 and notified the senior reactor operator functioning as the Assistant Shift Supervisor that the recorded time of 120.2 seconds exceeded the procedural limit of 120 seconds. The Assistant Shift Supervisor relayed this information to the Shift Supervisor on duty. The Shift Supervisor on duty failed to realize the Limiting Condition for Operation maximum allowable stroke time had been exceeded and Technical Specification ACTION 3.6.3.1 (b) applied. The error went undetected for approximately three days until at approximately 1630, February 26, 1988, the nonlicensed, utility Inservice Inspection Engineer completed a required review of SP-340A. Procedurally, the ISI engineer must review this procedure within 96 hours of performance. The ISI Engineer immediately notified the Shift Supervisor on duty (different person than on February 23, 1988) that the maximum allowable stroke time had been exceeded for DHV-41 during the February 23, 1988 surveillance. Action was initiated and completed shortly thereafter to ensure compliance with the ACTION statement. This event is being reported because of failure to enter the ACTION statement. The plant was operating in a condition prohibited by Technical Specifications in the period between the performance of the stroke time test and compliance with the ACTION requirements.

CAUSE

The cause of this event was personnel error on the part of shift supervisory personnel. It was not realized that a 120.2 second stroke time exceeded the maximum allowable stroke time and required action to comply with Technical Specifications. There were no unusual activities taking place in the control room that may have contributed to this event. SP-340A contains clear instruction on required action if a maximum stroke time is exceeded.

ANALYSIS

This event is being reported in accordance with 10CFR 50.73(a)(2)(i)(B) as a condition prohibited by Technical Specifications. According to Technical Specifications, the plant did not have proper isolation of the Decay Heat dropline in the period between February 23rd and February 26th. In actuality, the system was isolated by closed valves and maintained this way by a separate protective circuit called Automatic Closure Initiation [BD,PC] (ACI). ACI protects the Decay Heat system from over pressurization by closing DHV-3 and

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

DHV-4 [BD, ISV] whenever Reactor Coolant pressure exceeds 284 psig (see Figure 1). If an Engineered Safeguards containment isolation was required, the valve used to comply with ACTION 3.6.3.1(b), DHV-4, was already closed by ACT. Additionally, DHV-41 had been closed since the time stroke test meeting the requirements of containment isolation as described in the Crystal River Unit 3 FSAR section 5.3. Consequently, the safety of the plant was not degraded and the public was not endangered.

CORRECTIVE ACTION

In accordance with ACTION 3.6.3.1(b), DHV-4 was de-energized in the closed position. The valve stroke time of DHV-41 was later corrected to within the allowable limits by shortening the open travel of the valve. The shift supervisory personnel involved in the error were counselled on Technical Specification requirements of containment isolation valve stroke times. This event will be reviewed by all licensed operators.

ADDITIONAL INFORMATION

A related event that involved a containment isolation valve was reported in LER 86-06. Additionally, a report, LER 86-13, was submitted to document a failure to enter the proper Technical Specification ACTION statement.

# LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)

CRYSTAL RIVER UNIT 3

DOCKET NUMBER (2)

05000302

LER NUMBER (6)

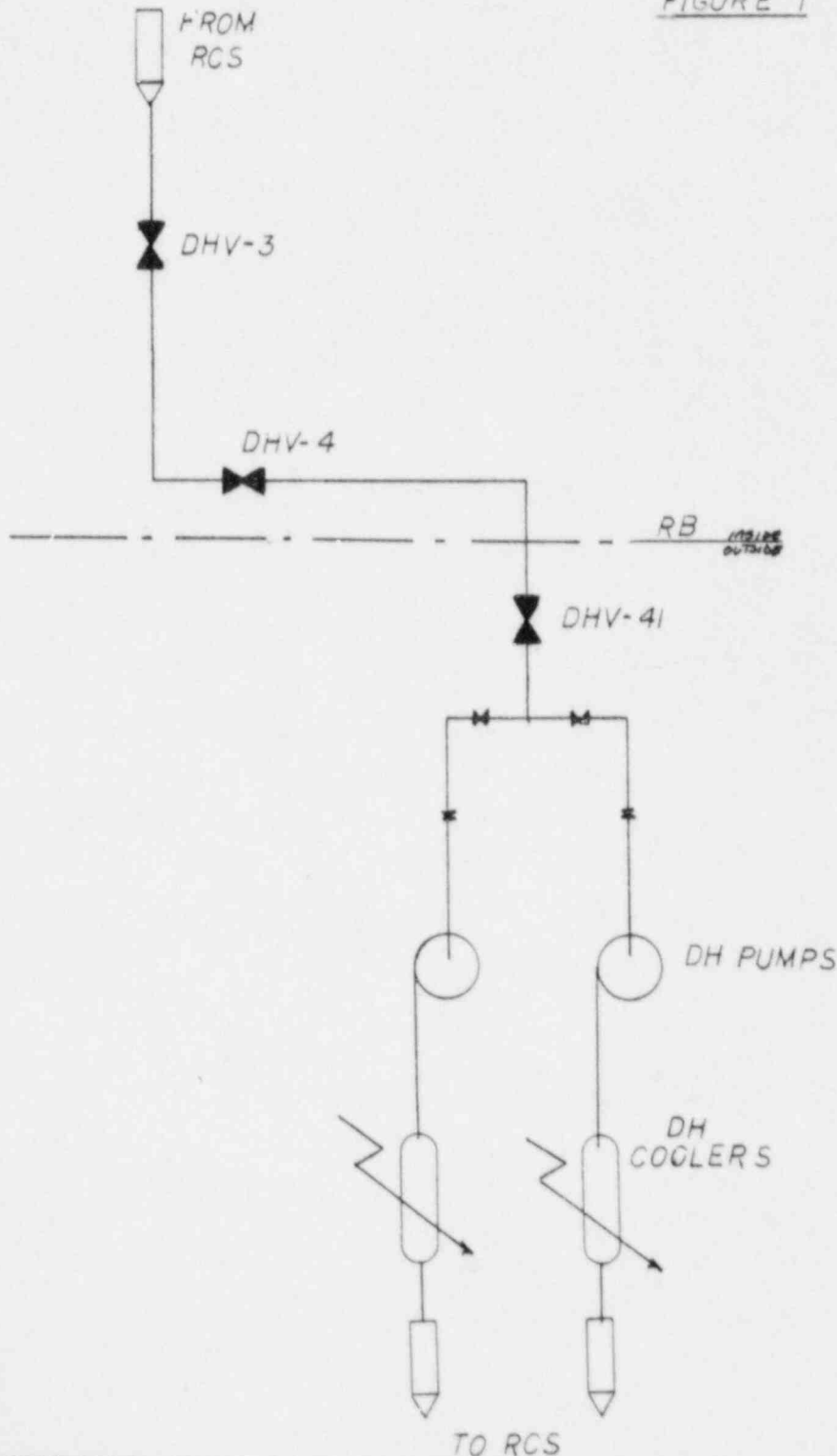
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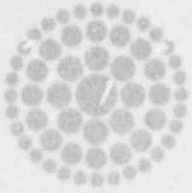
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TEXT (if more space is required, use additional NRC Form 366A's) (17)

FIGURE 1





**Florida  
Power**  
CORPORATION

March 24, 1988  
3F0388-21

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

Subject: Crystal River Unit 3  
Docket No. 50-302  
Operating License No. DPR-72  
Licensee Event Report No. 88-005-00

Dear Sir:

Enclosed is Licensee Event Report (LER) 88-005-00 which is submitted in accordance with 10 CFR 50.73.

Should there be any questions, please contact this office.

Sincerely,

K. R. Wilson  
Manager, Nuclear Licensing

WLR:mag

Enclosure

xc: Dr. J. Nelson (Grace)  
Regional Administrator, Region II

Mr. T. F. Steika  
Senior Resident Inspector

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