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AUTH.NAME AUTHOR AFFILIATION
NEELY,L.W. Florida Power & Light Co.
SAGER,D.A. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 90-003-00:900726,missed surveillance on radiation monitor returned to svc due to personnel error.

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P.O. Box 14000, Juno Beach, FL 33408-0420

FPL

August 16, 1990

L-90-300
10 CFR 50.73

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

Gentlemen:

Re: St. Lucie Unit 2
Docket No. 50-389
Reportable Event: 90-03
Date of Event: July 26, 1990
Missed Surveillance on Radiation Monitor
Returned to 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/GRM

Attachment

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

IE22
1/1

FPL Facsimile of NRC Form 366 (9-83)

LICENSEE EVENT REPORT (LER)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
St. Lucie Unit 2	0 5 0 0 0 3 8 9	1 OF 0 3

TITLE (4) MISSED SURVEILLANCE ON RADIATION MONITOR RETURNED TO SERVICE 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 N/A	DOCKET NUMBER(S)
0 7	2 6	9 0	9 0	0 0 3	0 0	0 8	1 6	9 0		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
L. W. Neely, 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)	☒ NO				

ABSTRACT (Limit to 1400 spaces. i.e. approximately fifteen single-space typewritten lines)(16)

On July 26, with Unit 2 in Mode 1 at 100% power, it was determined that the "B" Main Steam Line Radiation Monitor was returned to service following a power supply replacement on July 14, 1990 without performing required Technical Specification Surveillances. Unit 2 Technical Specification 4.3.3.1 required that the Channel Calibration and the Channel Functional Test be performed.

The root cause of this event was personnel error such that non-licensed utility maintenance personnel failed to follow a procedure.

Corrective actions: Chemistry Department personnel satisfactorily performed the required surveillances. The individuals involved were counseled. Instrumentation and Control Department will revise the Instrumentation and Control Test Control procedure such that a note is added to inform Chemistry or Health Physics, as necessary, before returning Technical Specification required radiation monitoring instrumentation back into service.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
St. Lucie Unit 2	0 5 0 0 0 3 8 9	9 0	0 0 3	0 0	0 2 OF 0 3

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

DESCRIPTION OF THE EVENT

On July 14, 1990, Unit 2 was in Mode 1 at 100% power, with the "B" Main Steam Line Radiation Monitor (EIIS:IL) out of service for the repair of a failed power supply. The "B" Main Steam Line Radiation Monitor was placed in the Equipment Out of Service Log. Non-licensed utility Instrumentation and Control (I&C) personnel replaced the 700 volt power supply for the "B" Main Steam Line Radiation Monitor. Upon completion of the repair, a utility licensed operator reviewed and approved the Nuclear Plant Work Order, authorized the return of service of the "B" Main Steam Line Radiation Monitor, and removed the item from the Equipment Out of Service Log.

On July 25, 1990, review of the Nuclear Plant Work Order was performed by utility maintenance supervisory personnel. It was determined that the proper retest requirements for returning to service of the "B" Main Steam Line Radiation Monitor was not given to utility Chemistry Department personnel, who normally perform the surveillances. On July 25, 1990, Chemistry Department non-licensed personnel satisfactorily performed a Channel Calibration and Channel Functional Test.

On July 26, 1990, it was determined by utility Technical Staff personnel that the the "B" Main Steam Line Radiation Monitor was returned to service on July 14, 1990 without a Channel Calibration and a Channel Functional Test performed as required in accordance with Surveillance Requirement 4.3.3.1 of the Unit 2 Technical Specifications.

CAUSE OF THE EVENT

The root cause of this event is that there was failure of utility non-licensed maintenance personnel to properly follow an I&C procedure, Instrumentation & Control Test Control. This procedure was stated to be used on the Nuclear Plant Work Order. Since I&C personnel do not perform either the Channel Calibration or the Channel Functional Test of the Main Steam Line Radiation Monitors, they normally contact Chemistry or Health Physics personnel to perform those surveillances. However, Appendix A.0.12, "Maintenance Test Sheets Power Supply Form", was not used and therefore not attached to the Nuclear Plant Work Order. Proper annotation of the form and attachment to the Nuclear Plant Work Order would have brought to the attention of the licensed utility operator the need for performance of the Channel Calibration and Channel Functional Test prior to returning the the "B" Main Steam Line Radiation Monitor to service.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
St. Lucie Unit 2	0 5 0 0 0 3 8 9	9 0	-- 0 0 3	-- 0 0	0 3 OF 0 3

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

ANALYSIS OF THE EVENT

This event is reportable under the requirements of 10 CFR 50.73.a.2.i.B, as an operation or condition prohibited by the St. Lucie Unit 2 Technical Specifications.

Technical Specification 3.3.3.1 requires that the "B" Main Steam Line Radiation Monitor be operable in Modes 1, 2, 3, and 4. Other instrumentation for radiation monitoring of the secondary system, the Steam Generator Blowdown Monitor and the Steam Jet Air Ejector Monitor, were operable during the time frame of July 14 through July 25, 1990. No indications of abnormal trends or alarm conditions in the secondary systems occurred during this period. A regularly scheduled surveillance of the "B" Main Steam Line Radiation Monitor performed July 25, 1990 was satisfactory and demonstrated that the monitor was operable while it was in service. Improper use of St. Lucie Plant procedure, Instrumentation and Control Test Control, QI11-PR/PSL-4, by non-licensed utility maintenance personnel resulted in the inability of a licensed reactor operator to properly assess that the testing requirements were not completed. There were no unusual characteristics of the work location that contributed to the error.

Thus, the health and safety of the public were not at risk during this event.

CORRECTIVE ACTIONS

1. Chemistry non-licensed utility personnel satisfactorily performed a Channel Calibration and a Channel Functional Test of the "B" Main Steam Line Radiation Monitor.

2. I&C personnel were counseled on the need to follow procedures.

3. I&C Department will revise the Instrumentation and Control Test Control procedure such that a note is added to inform Chemistry or Health Physics, as necessary, before returning Technical Specification required radiation monitoring instrumentation back into service.

ADDITIONAL INFORMATION

COMPONENT FAILURES

NONE

PREVIOUS SIMILAR EVENTS

The most recent similar event is LER 335-89-006, which describes a radiation effluent monitor being out of service due to having electric leads reversed.

Another similar event is LER 335-87-009, which describes a fuel handling building ventilation radiation monitor being out of service due to cognitive personnel error on the part of utility licensed personnel.