

# REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8708200015 DOC. DATE: 87/08/14 NOTARIZED: NO DOCKET #  
 FACIL: 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251  
 AUTH. NAME AUTHOR AFFILIATION  
 SALAMON, G. Florida Power & Light Co.  
 WOODY, C. O. Florida Power & Light Co.  
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-015-00: on 870715, technicians failed to deactivate inoperable containment isolation valve within 4 h as required by Tech Specs. Caused by personnel error. Procedure completion responsibility centralized. W/870814 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4  
 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

## NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL		RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
	PD2-2 LA	1 1		PD2-2 PD	1 1
	McDONALD, D	1 1			
INTERNAL:	ACRS MICHELSON	1 1		ACRS MOELLER	2 2
	AEOD/DOA	1 1		AEOD/DSP/NAS	1 1
	AEOD/DSP/ROAB	2 2		AEOD/DSP/TPAB	1 1
	DEDRO	1 1		NRR/DEST/ADS	1 0
	NRR/DEST/CEB	1 1		NRR/DEST/ELB	1 1
	NRR/DEST/ICSB	1 1		NRR/DEST/MEB	1 1
	NRR/DEST/MTB	1 1		NRR/DEST/PSB	1 1
	NRR/DEST/RSB	1 1		NRR/DEST/SGB	1 1
	NRR/DLPQ/HFB	1 1		NRR/DLPQ/GAB	1 1
	NRR/DOEA/EAB	1 1		NRR/DREP/RAB	1 1
	NRR/DREP/RPB	2 2		NRR/PMAS/ILRB	1 1
	REG FILE 02	1 1		RES DEPY GI	1 1
	RES TELFORD, J	1 1		RES/DE/EIB	1 1
	RGN2 FILE 01	1 1			
EXTERNAL:	EG&G GROH, M	5 5		H ST LOBBY WARD	1 1
	LPDR	1 1		NRC PDR	1 1
	NSIC HARRIS, J	1 1		NSIC MAYS, G	1 1



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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										PAGE (3) 1 OF 0   3					
TITLE (4) Failure to Deactivate Inoperable Containment Isolation Valve Within 4 Hours as Required by Technical Specifications 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)	
																		N/A						0   5   0   0   0	
0   7		1   5		8   7		8   7		0   1   5		0   0		0   8		1   4		8   7								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)						60.73(a)(2)(iv)						73.71(b)			
				20.405(a)(1)(i)						60.38(c)(1)						60.73(a)(2)(v)						73.71(c)			
				20.405(a)(1)(ii)						60.38(c)(2)						60.73(a)(2)(vii)						OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
				20.405(a)(1)(iii)						X 60.73(a)(2)(ii)						60.73(a)(2)(viii)(A)									
				20.405(a)(1)(iv)						60.73(a)(2)(iii)						60.73(a)(2)(viii)(B)									
				20.405(a)(1)(v)						60.73(a)(2)(iv)						60.73(a)(2)(ix)									
LICENSEE CONTACT FOR THIS LER (12)																									
NAME																TELEPHONE NUMBER									
Gabe Salamon, Compliance Engineer																AREA CODE		3   1   0   5   2   4   6   1   -   6   5   6   0							
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																									
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC															
X	B   D	8   4	M   1   2   0	Y																					
SUPPLEMENTAL REPORT EXPECTED (14)																EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR					
YES (If yes, complete EXPECTED SUBMISSION DATE)																X NO									

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

The solenoid for valve CV-956B was discovered to be causing a ground on July 13, 1987, with Unit 4 in mode 1. The valve was declared out of service (OOS), and the fuse was pulled, in compliance with Technical Specification (TS) 3.3.3, which requires isolation of each affected penetration within 4 hours. The cause of the short was deteriorated insulating tape. Following repair, power was restored at 2318 on July 14, and post-maintenance testing was performed with satisfactory results. At approximately 0630 on July 15, the technician notified the Shift Technical Advisor (STA) that In-Service Testing (IST) needed to be performed. This was completed at 0645, however local verification of valve position, as required by OP 0209.1, "Valve Exercising Procedure", was not performed. A new IST was performed at 1805 on July 16, with satisfactory results. As the valve is OOS until completion of a satisfactory IST, valve CV-956B was OOS without complying with TS 3.3.3 between 0318, July 15, and 1805, July 16. The failure to perform the IST within 4 hours was due to personnel error, in that the STA was not notified in a timely manner. The initial IST inadequacy was also due to personnel error in that the STA failed to follow procedure OP 0209.1. Responsibility for the completion of all maintenance required IST's will be centralized in the Maintenance Department.

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PDR ADOCK 05000251  
S PDR

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Turkey Point Unit 4	0   5   0   0   0   2   5   1	8   7	—   0   1   5	—   0   0	0   2	OF	0   3

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

EVENT

The solenoid for Valve CV-956B, the pressurizer liquid sample isolation control valve (EIIIS:BD,KN), was discovered to be causing a hard ground on the 4B D.C. Bus on July 13, 1987, with Unit 4 in Mode 1. Upon discovery of the ground, the valve was declared out of service (OOS) and the fuse was pulled. This was performed in compliance with Technical Specification 3.3.3, which requires that "with one or more of the isolation valve(s)... inoperable, maintain at least one isolation valve operable in each affected penetration that is open and: a) restore the inoperable valve to operable status within 4 hours, or b) isolate each affected penetration within 4 hours by use of at least one deactivated automatic containment isolation valve secured in the isolation position, or.... d) be in at least hot standby within the next 6 hours..." A Plant Work Order (PWO) was prepared and repair was initiated at 1530 on July 14. The PWO identified both post-maintenance (PM) testing and in-service testing (IST) as being required prior to returning the valve to service. The cause of the ground was determined to be insulating tape which had deteriorated from normal aging. In the process of cleaning and retaping the connection, the power lead to the solenoid was lifted and then reterminated. Following the repair of the connection, the technician requested restoration of power and performed the required PM testing (cycling of the valve and verification of position indication) with satisfactory results. The fuse was reinstalled by a Reactor Control Operator (RCO) in accordance with the above request at 2318 on July 14. At approximately 0630 on July 15, the RCO, upon identifying the valve being OOS in the Equipment Out of Service (EOOS) Log and realizing that IST was needed, notified the Shift Technical Advisor (STA) that IST needed to be performed (the STA is the acting IST coordinator when the plant IST Coordinator is not on site). IST of the valve requires cycling the valve, local and remote verification of valve position, and satisfactory timing of the valve stroke. The IST was completed at 0645, however local verification of valve position was not performed. The plant IST coordinator, upon review of the above IST results, identified this discrepancy. A new IST, meeting all requirements, was performed at 1805 on July 16, with satisfactory results. As the valve cannot be considered to be in service until completion of a satisfactory IST, valve CV-956B was technically OOS without complying with the requirements of TS 3.3.3 between 0318, July 15, and 1805, July 16.

CAUSE OF EVENT

The event has two deficiencies: first, the failure to assure that the IST was performed within 4 hours following restoration of power to valve CV-956B, and second, the failure to assure that the IST was adequate.

The cause of the failure to perform the IST within the 4 hour time limit is personnel error. Procedure AP 0190.28, "Postmaintenance Testing", requires the maintenance foreman/chief or supervisor to notify the IST Coordinator or the STA prior to the commencing the work. The STA was not notified until approximately 7 hours after the fuse was reinstalled. Without receiving the required notification,

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Turkey Point Unit 4	0 5 0 0 0 2 5 1	8 7	0 1 5	0 0	0 3	OF	0 3

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

scheduling the test in order to comply with the Technical Specifications was missed. Primary responsibility for assuring that LCO's are complied with rests with the Plant Supervisor-Nuclear. Even though he was notified via a temporary lift that the fuse was being reinstalled, no programmatic verification of any applicable LCO's was in place. Consequently, the 4 hour LCO which was entered upon installation of the fuse was not emphasized and was missed.

The failure to assure that the initial IST was adequate was also due to personnel error in that the STA failed to follow procedure. Procedure OP 0209.1, "Valve Exercising Procedure", requires both local and remote position indication verification of valve CV-956B after any maintenance, in addition to verifying the above every 2 years. In order to determine the acceptance criteria for the valve stroke time, the STA reviewed the results of previous tests, and noticed that the valve was tested within the last 2 years. The STA did not review OP 0209.1, which required local position verification after any maintenance. As result, he did not require this to be performed.

#### ANALYSIS OF EVENT

One of the ways in which the release of fission products from the containment is limited is by the isolation of process lines by the Containment Isolation System (CIS). The CIS imposes double barriers in each line which penetrates the containment. While valve CV-956B was technically OOS during this event, it was capable of performing its design function had it been necessary. This was demonstrated by the initial PM test, and confirmed by the initial and final IST's. Additionally, during the time that valve CV-956B was inoperable, the redundant containment isolation valve, CV-953, was operable. Based on the above, the health and safety of the public were not affected.

#### CORRECTIVE ACTIONS

- 1) Valve CV-956B was in-service tested with satisfactory results.
- 2) Responsibility for the scheduling, coordination, and timely completion of all IST's required because of maintenance will be centralized in the Maintenance Department. This will be implemented through either procedure revisions or new procedures.

#### ADDITIONAL DETAILS

Valve Operator Manufacturer: Masoneilan International, Inc. Operator Model Number: 38-2057.

Similar occurrences: LER's 251-85-24, 251-86-23



AUGUST 14 1987

L-87-332  
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: 87-15  
Date of Event: July 15, 1987  
Failure to Deactivate Inoperable Containment Isolation Valve Within  
4 Hours as Required by Technical Specifications 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,

  
C. O. Woody  
Group Vice President  
Nuclear Energy

COW/SDF/gp

Attachment

cc: Dr. J. Nelson Grace, Regional Administrator, Region II, USNRC  
Senior Resident Inspector, USNRC, Turkey Point Plant

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