NRC Form 366
(9-83)

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

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
ST. LUCIE UNIT 1	0 5 0 0 0 3 3 5	1 OF 0 3

TITLE (4)
INOPERABLE CONTAINMENT ISOLATION VALVE

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	2 8	8 5	8 5	0 0 2	0 1				N/A	0 5 0 0 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)	X 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)	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
Dave Stewart, Technical Staff Dan West, Technical Staff	AREA CODE 3 0 5 — 4 6 5 - 3 5 5 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	
A				No							

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)

EVENT: While in Mode 1, at normal full power, the inboard valve of a series set of containment isolation valves was found inoperable in the open position. Those containment isolation valves supply component cooling water to the reactor coolant pumps. The inboard valve was discovered to be incorrectly connected to an emergency backup nitrogen system. This condition is contrary to Technical Specification 3.6.3.1. The valve was observed to move freely and was placed in an operable status within an hour. The piping and components supplied by these series isolation valves are internal to the containment and comprise a closed system, subject only to potential bypass leakage. Multiple component failures, in addition to one valve inoperable in the open position, would be required to breech containment integrity. There was no component failure in this event. The health and safety of the public was not adversely affected by this event.

CAUSE OF EVENT: Investigation indicates the backup nitrogen system was connected by procedure while making D.C. ground checks on December 31, 1984. Due to a mechanical connector problem, the valve was not immediately disconnected.

CORRECTIVE ACTIONS: As a corrective action, all procedures allowing emergency use of this backup system now require the connectors to be either hand held or entered in the Jumpers and Disconnected Leads Log.

IE22
1/1

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

EVENT:

On December 31, 1984 during normal full power operation, Operations personnel were attempting to locate and isolate a ground fault indicated on the 1B DC BUS. The ground isolation procedure requires that a component cooling water to reactor coolant pump supply header instrument air operated containment isolation valve (HCV 14-7) be blocked open by temporary connection to a nitrogen supply system while the valve's breaker is momentarily deenergized for a ground check. The valve's mechanical jumper was installed by the Nuclear Operator (NO) and the breaker deenergized by the Nuclear Watch Engineer (NWE). The NWE observed that the ground fault indication failed to clear and immediately reenergized the breaker, reset the valve's solenoid, and instructed the NO to remove the mechanical jumper from the valve.

The NO found that he could not disengage the quick disconnect coupling from the valve. He then contacted his NWE and notified him of the problem. The NWE promptly contacted the Shift Maintenance Supervisor for immediate assistance in decoupling the jumper. Concurrently the NWE had the NO prepare and route a PWO to document the maintenance assistance required.

The Maintenance Supervisor dispatched a mechanic who paged the NO and inquired as to the valve's location. The NO and NWE then assumed that the jumper would be removed by the mechanic. The DC ground was finally located and isolated in an unrelated part of the plant and the DC ground isolation procedure was terminated without the jumper in question ever being removed.

The PWO written by the NO for documentation was forwarded to Mechanical Maintenance where it was processed on a routine basis. Eventually the PWO was determined to involve I&C Department equipment and was forwarded to that group. On February 28, 1985 I&C personnel presented the PWO to the Assistant Nuclear Plant Supervisor for the necessary review and approvals prior to the commencement of any safety related job. The ANPS immediately recognized the containment isolation function of the valve and declared the four hour action statement required by the Technical Specifications. I&C personnel immediately commenced work on the valve. Less than one hour after declaration of the action statement the temporary jumper was removed and the valve was returned to service.

Determination of the series of events leading to this incident was hampered due to the fact that the NWE involved had terminated his employment with the company before this problem was identified. The root cause of the problem seems to be that both the NWE and NO assumed that because this was a seemingly minor mechanical problem (decoupling a quick disconnect fitting) the arrival of a mechanic on the scene assured that the job would be accomplished. This error of assumption was compounded by no entries being made in the appropriate problem tracking systems (Watchstander Logs, Equipment Out Of Service Log, etc.)

CORRECTIVE ACTION:

As a corrective action the DC ground isolation procedure has been changed to require the temporary nitrogen jumper to be continuously hand held or entered into the Jumper Log. In addition, Assistant Nuclear Plant Supervisor review and sign off is now required when the ground isolation procedure is completed or terminated for any reason. Furthermore, the specifics of this particular event will be emphasized to all Operators during requalification training.

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

EVALUATION:

It should be noted that although HCV 14-7 was blocked open for a total of 59 days, the Maintenance PWO System did finally expose the problem. Additionally, the redundant series isolation valve was fully operable for the entire period. Furthermore, the system involved (component cooling water) is a closed system within containment. Therefore, for a release to have occurred via this pathway, multiple failures would have been necessary: (Accident in containment + CCW line break inside containment + redundant containment isolation valve failure + CCW line break outside containment.) Thus it can be stated that the health and safety of the general public was not affected by this event.

FLORIDA POWER & LIGHT COMPANY

MAY 1 1985

L-85-139

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

Gentlemen:

Re: Reportable Event 85-02, Rev. 1
St. Lucie Unit 1
Date of Event: February 28, 1985
Inoperable Containment Isolation Valve

The attached revised Licensee Event Report is being submitted pursuant to the requirements of 10 CFR to clarify notification of the subject event. This revision corrects a typographical error made on page 2 of the report sent on April 1, 1985 and adds information on component failure.

Very truly yours,

J. W. Williams, Jr.
Group Vice President
Nuclear Energy

JWW/SAV/js

Attachment

cc: Dr. J. Nelson Grace, Region II, USNRC
Harold F. Reis, Esquire
File 933.1
PNS-LI-85-136v

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PEOPLE . . . SERVING PEOPLE