

Florida Power

CORPORATION

Crystal River Unit 3

Docket No. 50-302

May 14, 1996
3F0596-24

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D. C. 20555-0001

Subject: Licensee Event Report (LER) 96-013-00

Dear Sir:

Please find the enclosed Licensee Event Report (LER) 96-013-00. This report is submitted by Florida Power Corporation in accordance with 10 CFR 50.73.

Sincerely,

B. J. Hickle, Director
Nuclear Plant Operations

TWC:ff

Attachment

xc: Regional Administrator, Region II
Project Manager, NRR
Senior Resident Inspector

200092

JE22
1/1

EXPIRES 5/31/95

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HOURS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON DC 20503.

FACILITY NAME (1)

CRYSTAL RIVER UNIT 3 (CR-3)

DOCKET NUMBER (2)

0 5 0 0 0 3 0 2 1 OF 0 8

PAGE (3)

TITLE (4)

Failure to Use Self-Checking by Operator Leads to Unplanned Actuation of Engineered Safeguards Pump

| 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 (9) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 0 | 4 | 1 | 4 | 9 | 6 | 9 | 6 | 0 | 1 | 3 | 0 | 0 | 0 | 5 | 0 | 0 | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OPERATING MODE (9) | | | | | | | | | | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (CHECK ONE OR MORE OF THE FOLLOWING) (11) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | 20.402(b) | | | | | | | | 20.405(c) | | | | | | | | X | | | | | | | | 50.73(a)(2)(iv) | | | | | | | | 73.71(b) | | | | | | | |
| POWER LEVEL (10) | | | | | | | | | | 20.405(a)(1)(i) | | | | | | | | 50.36(c)(1) | | | | | | | | | | | | | | | | 50.73(a)(2)(v) | | | | | | | | 73.71(c) | | | | | | | |
| 0 | | | | | | | | | | 0 | | | | | | | | 0 | | | | | | | | | | | | | | | | 50.73(a)(2)(vii) | | | | | | | | OTHER (Specify in Abstract below and in Text, NRC Form 386A) | | | | | | | |
| | | | | | | | | | | 20.405(a)(1)(ii) | | | | | | | | 50.36(c)(2) | | | | | | | | | | | | | | | | 50.73(a)(2)(viii)(A) | | | | | | | | | | | | | | | |
| | | | | | | | | | | 20.405(a)(1)(iii) | | | | | | | | 50.73(a)(2)(i) | | | | | | | | | | | | | | | | 50.73(a)(2)(viii)(B) | | | | | | | | | | | | | | | |
| | | | | | | | | | | 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

T.W. Catchpole, Sr. Nuclear Licensing Engineer

TELEPHONE NUMBER

AREA CODE

3 5 2 5 6 3 - 4 6 0 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE IN THIS REPORT (13)

| CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NRPDS | CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NRPDS |
|-------|--------|-----------|--------------|---------------------|-------|--------|-----------|--------------|---------------------|
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SUPPLEMENTAL REPORT EXPECTED (14)

| YES | NO | EXPECTED SUBMISSION DATE (15) | MONTH | DAY | YEAR |
|--------------------------|-------------------------------------|-------------------------------|-------|-----|------|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | | | | |

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

On April 14, 1996, Florida Power Corporation's Crystal River Unit 3 (CR-3) was preparing to start up from a refueling outage with the unit in MODE 5 (COLD SHUTDOWN). At approximately 1418 hours, during the performance of a monthly automatic actuation logic test surveillance, an improper switch alignment resulted in the auto start of Decay Heat Closed Cycle Cooling Water Pump DCP-1A. The Nuclear Operator (NO) had mistakenly placed the "A" HPI AUTO TEST SELECT switch in the "off" position when the procedure step instruction was to place the HPI AUTO TEST GRP 3 switch to the "off" position. This resulted in the unplanned start of DCP-1A. The mispositioned switch was returned to its proper position and DCP-1A was secured. No components were damaged as a result of this event. The cause of the event was operator error in failing to use self-checking when performing complex control room manipulations. Actions taken include issuance of an Operations Study Book entry as a "lessons learned" and discussions between the Manager, Nuclear Plant Operations and shift personnel regarding expectations pertaining to control of control room activities and the requirements for self checking. In addition, a procedure reader has been assigned to the board operator for complex surveillance procedures which direct operators to reposition control room switches associated with Engineered Safeguards channels.

EXPIRES 5/31/95

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0 5 0 0 0 3 0 2 1 OF 0 8

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| 0 | 4 | 1 | 4 | 9 | 6 | 9 | 6 | 0 | 1 | 3 | 0 | 0 | 0 | 5 |

OPERATING
MODE (9)

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (CHECK ONE OR MORE OF THE FOLLOWING) (11)

POWER
LEVEL
(10)

0 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)

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)

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|-------|--------|-----------|---------------|------------------------|-------|--------|-----------|---------------|------------------------|
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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)

On April 14, 1996, Florida Power Corporation's Crystal River Unit 3 (CR-3) was preparing to start up from a refueling outage with the unit in MODE 5 (COLD SHUTDOWN). At approximately 1418 hours, during the performance of a monthly automatic actuation logic test surveillance, an improper switch alignment resulted in the auto start of Decay Heat Closed Cycle Cooling Water Pump DCP-1A. The Nuclear Operator (NO) had mistakenly placed the "A" HPI AUTO TEST SELECT switch in the "off" position when the procedure step instruction was to place the HPI AUTO TEST GRP 3 switch to the "off" position. This resulted in the unplanned start of DCP-1A. The mispositioned switch was returned to its proper position and DCP-1A was secured. No components were damaged as a result of this event. The cause of the event was operator error in failing to use self-checking when performing complex control room manipulations. Actions taken include issuance of an Operations Study Book entry as a "lessons learned" and discussions between the Manager, Nuclear Plant Operations and shift personnel regarding expectations pertaining to control of control room activities and the requirements for self checking. In addition, a procedure reader has been assigned to the board operator for complex surveillance procedures which direct operators to reposition control room switches associated with Engineered Safeguards channels.

LICENSEE EVENT REPORT (LER)
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| FACILITY NAME (1) CRYSTAL RIVER UNIT 3 (CR-3) | 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 DESCRIPTION

On April 14, 1996, Florida Power Corporation's Crystal River Unit 3 (CR-3) was preparing to start up from a refueling outage with the unit in MODE 5 (COLD SHUTDOWN). The "B" Decay Heat Removal (DHR) [BP] system was in service. At approximately 1418 hours, during the performance of Surveillance Procedure SP-358C "Operations ES Monthly Automatic Actuation Logic Functional Test #3", an improper switch alignment resulted in the auto start of Decay Heat Closed Cycle Cooling Water (DC) Pump DCP-1A [CC,P]. The DC system provides emergency cooling of Engineered Safeguards (ES) components. The Nuclear Operator (NO) had mistakenly placed the "A" HPI AUTO TEST SELECT switch in the "off" position when the procedure step instruction was to place the HPI AUTO TEST GRP 3 switch in the "off" position. This resulted in the unplanned start of DCP-1A because the associated time delay relays which establish the start signal had not been reset and restoration of the test relays occurred when the HPI AUTO TEST SELECT switch was placed in the "off" position.

The mispositioned switch was returned to its proper position and DCP-1A was secured. A Problem Report was generated and a 4-hour notification was made to the NRC at 1631 hours in accordance with 10CFR50.72(b)(2)(ii) to report an automatic actuation of an Engineered Safety Feature (ESF). This notification was assigned Event Number 30286.

This report is being submitted in accordance with 10CFR50.73(a)(2)(iv).

EVENT EVALUATION

The Engineered Safeguards Actuation System [JE] (ESAS) employs three channels for each monitored variable. Each set of three channels is arranged to obtain a 2-out-of-3 voting redundancy for the monitored variable to detect a loss of the Reactor Coolant System [AB](RCS) boundary integrity. Redundancy in the operation of ES equipment is obtained by employing two sets of three instrumentation channels which serve actuation Trains "A" and "B". Each of the components actuated by the ESAS Functions has an associated automatic actuation logic matrix. The ES Matrix signal is blocked during testing to prevent actuation of the equipment. A test circuit is provided, with control on the control room safeguard panel, to allow testing of a preselected group of output relays of two channels of the same function. It yields a true two-out-of-three actuation in the control circuit of each of the auxiliaries controlled by the preselected output relays. During testing, the end devices are blocked downstream of the matrices and circuit monitoring devices ensure matrix actuation and circuit restoration after testing. All output relays may be de-energized in the same manner in order to test the safeguards actuation system.

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

The engineered safeguards channels in each "Train of Actuation" are designated as follows:

| SYSTEM NAME | COMMON ABBREVIATION | CHANNEL DESIGNATIONS | | |
|--------------------------|------------------------|----------------------|-----|-----|
| High Pressure Injection | HPI | RC1 | RC2 | RC3 |
| Low Pressure Injection | LPI | RC4 | RC5 | RC6 |
| RB Isolation and Cooling | RBIC | RB1 | RB2 | RB3 |
| RB Spray | RBS | RB4 | RB5 | RB6 |

SP-358C performs a functional test (verification of contact actuation) for operability verification of one combination of the three 2 out of 3 logic matrices for High Pressure Injection (HPI) [BQ], Low Pressure Injection (LPI) [BP], and Reactor Building Isolation & Cooling (RBIC) [BK] for the ESAS "A" and "B" trains. The section of the procedure being performed prior to this event involved the verification of "Test-3" (RC3,RC1) Mode Operability. The "A" Train Test Group 3 equipment consists of DC Air Handling Unit [CC,FAN] AHF-15A, Reactor Building Fan Assemblies [BK,FAN] AHF-1A and AHF-1C, Emergency Feedwater Pump [BA,P] EFP-1, Nuclear Services Seawater Pumps [KG,P] RWP-2A and RWP-3A, Nuclear Closed Cycle Cooling Water Pump [CC,P] SWP-1A, and Decay Heat Closed Cycle Cooling Water Pump [BP,CC,P] DCP-1A. DCP-1A was the only component which started as a result of this event as all other components were either tagged out, already running, or prevented from operating due to the system alignment.

Three test and channel cabinets are located in the control room (Figure 1). The ES channel test cabinets have test switches to trip each of the ES channels. The bistables for HPI & LPI channels can be placed in the test operate position tripping the associated channels for the cabinet, i.e. cabinet #1 contains RC1 & RC4, cabinet #2 contains RC2 & RC5, and cabinet #3 contains RC3 & RC6. SP-358C is written to be performed by two Operations personnel reporting to the Shift Supervisor on Duty (SSOD); however, certain steps require the operator to move back and forth between the Main Control Board [MCBD] (MCB) and the ES Cabinets to reposition switches and verify test lights.

At the time of this event a Nuclear Operator (NO) and the Clearance Chief Nuclear Operator were performing the SP-358C procedure. The two control room supervisors were working on outage related activities at their desks. The Chief Nuclear Operator (CNO) was performing post maintenance valve stroking in communication with a building operator.

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

Due to the plant configuration at the time of this event, the effect on the plant was extremely minor. Only pump DCP-1A started. No system, train, or safety function was lost and no components were damaged.

CAUSE

The cause of this event was personnel error by the responsible operator who failed to perform adequate self-checking when performing complex control room manipulations.

A Human Performance Evaluation System (HPES) review was conducted which identified several contributing causes as follows:

1. There were many distractions in progress in the immediate vicinity of the operator performing the surveillance. The other board operator was communicating with operators in the plant while stroking valves whose controls were in close proximity to the ES panel. Additionally, there were two electricians and two engineers working in the same area discussing the installation of new flow indicators;
2. SP-358C is a complicated procedure consisting of 145 pages which requires very close scrutiny of actions and accurate use of the self-checking technique "STOP, THINK, ACT, REVIEW" (STAR);
3. The control room supervisor did not perform a formal pre-job briefing to stress the use of STAR;
4. A third operator was not used to read the procedure to the operator which may have slowed the pace of performance and enhanced the use of STAR;
5. The supervisor and the operator failed to acknowledge the need to reduce control room distractions during the performance of the procedure;
6. The operator was assigned two procedures in the afternoon of a twelve-hour shift beginning 0700 hours and indicated he felt a perceived expectation to complete the surveillance by the end of the shift.
7. The MCB switch mistakenly selected (HPI AUTO TEST SELECT) is labeled similarly to the correct switch (HPI AUTO TEST GRP 3). See Figure 2.

IMMEDIATE CORRECTIVE ACTION

The affected switches were placed in the correct position and DCP-1A was secured.

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0 5 0 0 0 3 0 2 9 6 --- 0 1 3 --- 0 0 0 5 OF 0 8

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

ADDITIONAL CORRECTIVE ACTION

1. The Manager, Nuclear Plant Operations (MNPO) discussed the incident with the responsible shift personnel stressing the seriousness of the event, the need to control Control Room activities, and the need to avoid perceived pressure to quickly complete a test.
2. The MNPO provided a letter to the NO stressing the requirements of self-checking (STAR) as part of the Reactor Operator (RO) job qualifications. The NO was informed that future involvement in events due to failure to utilize STAR would be viewed as not being able to maintain the fundamental qualifications of an RO.
3. An Operation Study Book (OSB) entry has been issued to allow operations personnel to learn from the event.
4. The MNPO issued a Night Order effective May 13, 1996 providing an expectation for the assignment of a procedure reader to the NO for complex surveillance procedures which direct operators to reposition control room switches. Procedures applicable to this expectation include SP-332 "Monthly Steam Line and Feedwater Isolation Functional Test", SP-333 "Control Rod Exercises", SP-356 "ES Manual Actuation Channel Functional Test for RB Isolation and Cooling", SP-357 "ES Manual Actuation Channel Functional Test for HPI and LPI", and SP-358 A, B, and C "Operations ES Automatic Actuation Logic Functional Tests 1, 2, and 3".

ACTION TO PREVENT RECURRENCE

SP-358A, B, and C will be reviewed for human performance improvements by August 1, 1996. This review will address the need for improvements in nomenclature, the need to color switch bezels for differentiation, and incorporation of a note on the front of the procedure to stress STAR. Based on this review, any necessary procedure changes will be made by September 30, 1996.

PREVIOUS SIMILAR EVENTS

There have been thirteen previous reports of unplanned/inadvertent ES actuations involving personnel errors. These include six resulting in actuation of an Emergency Diesel Generator [EK,DG] (LER's 85-005, 85-006, 85-019, 86-005, 87-028, and 95-002); four resulting in actuation of Emergency Feedwater [BA] (LER's 88-002, 89-003, 89-023, and 90-016); one resulting in actuation of High Pressure Injection [BQ] (LER 77-149); one resulting in actuation of Low Pressure Injection [BP] (LER 85-008); and one resulting in actuation of DCP-1A (LER 87-027). The actuation of

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| | 0 5 0 0 0 3 0 2 9 6 | 0 1 3 | 0 0 | 0 6 | OF 0 8 |

TEXT (If more space is required, Use additional NRC Form 365A's (17))

DCP-1A was caused by an Instrument and controls technician who inadvertently valved out the wrong transmitter which sent a signal to ES Channels 1A and 1B satisfying the 2 out of 3 logic and resulting in an "A" train ES actuation.

ATTACHMENT

- Figure 1 - Control Room ES Cabinet Locations
Figure 2 - ES Main Control Board Test Switch Arrangement

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

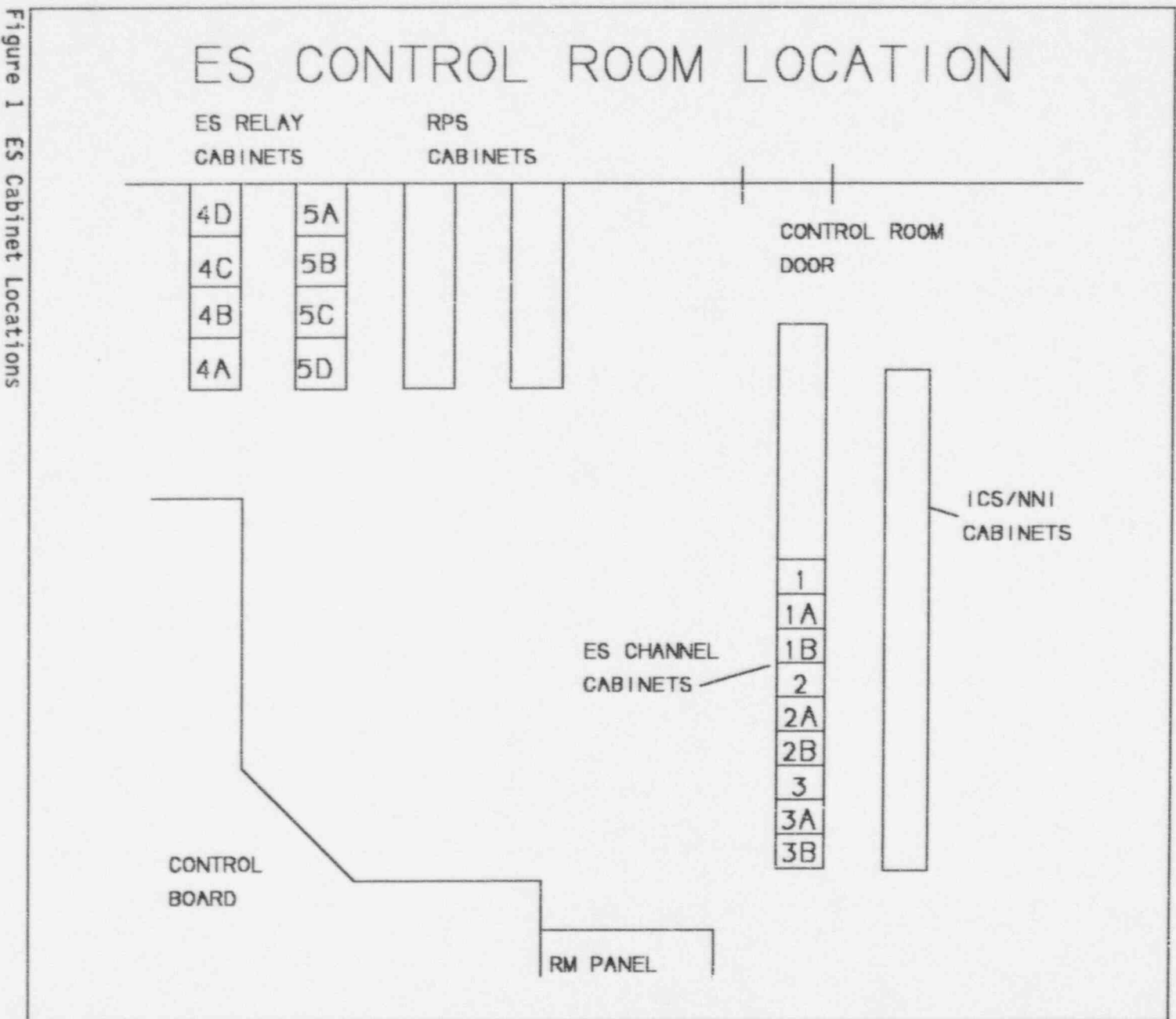


Figure 1 ES Cabinet Locations

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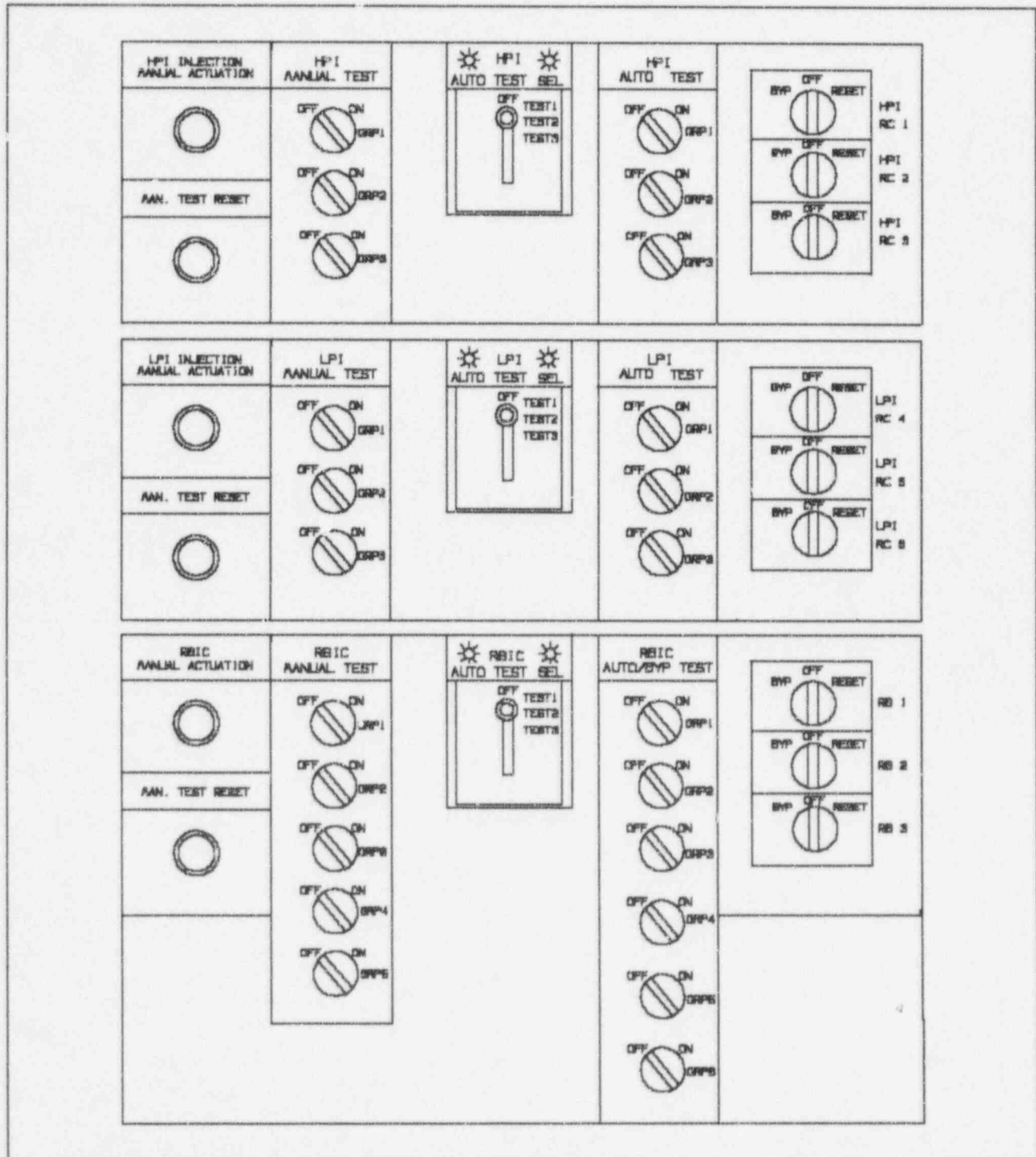


Figure 2 ES MCB Test Switch Arrangement