

# ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:8905250219 DOC.DATE: 89/05/10 NOTARIZED: NO DOCKET #  
 FACIL:50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251  
 AUTH.NAME AUTHOR AFFILIATION  
 FORD,B.L. Florida Power & Light Co.  
 WOODY,C.O. Florida Power & Light Co.  
 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-002-00:on 890412,3A & 4A high head safety injection  
 (SI) pumps autostarted after SI signal received.

W/8 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 4  
 TITLE: 50.73/50.9 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
EDISON,G	1 1		
INTERNAL: ACRS MICHELSON	1 1	ACRS MOELLER	2 2
ACRS WYLIE	1 1	AEOD/DOA	1 1
AEOD/DSP/TPAB	1 1	AEOD/ROAB/DSP	2 2
DEDRO	1 1	IRM/DCTS/DAB	1 1
NRR/DEST/ADE 8H	1 1	NRR/DEST/ADS 7E	1 0
NRR/DEST/CEB 8H	1 1	NRR/DEST/ESB 8D	1 1
NRR/DEST/ICSB 7	1 1	NRR/DEST/MEB 9H	1 1
NRR/DEST/MTB 9H	1 1	NRR/DEST/PSB 8D	1 1
NRR/DEST/RSB 8E	1 1	NRR/DEST/SGB 8D	1 1
NRR/DLPQ/HFB 10	1 1	NRR/DLPQ/PEB 10	1 1
NRR/DOEA/EAB 11	1 1	NRR/DREP/RPB 10	2 2
NUDOCS-ABSTRACT	1 1	<u>REG FILE</u> 02	1 1
RES/DSIR/EIB	1 1	RES/DSR/PRAB	1 1
RGN2 FILE 01	1 1		
EXTERNAL: EG&G WILLIAMS,S	4 4	FORD BLDG HOY,A	1 1
L ST LOBBY WARD	1 1	LPDR	1 1
NRC PDR	1 1	NSIC MAYS,G	1 1
NSIC MURPHY,G.A	1 1		

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*AD*  
*[Signature]*



## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)										DOCKET NUMBER (2)										PAGE (3)									
Turkey Point Unit 4										0 5 0 0 0 2 5 1										1 OF 0 3									
TITLE (4) "A" Train Safeguards Actuation Due to Personnel Error While Installing Fuses in Safeguards Rack																													
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 4	1 2	8 9	8 9	0 0 2	0 0	0 5	1 0	8 9	N/A					0 5 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)				<input checked="" type="checkbox"/> 50.73(a)(2)(iv)				73.71(b)														
POWER LEVEL (10)			0 0 0				20.405(a)(1)(i)				50.38(c)(1)				50.73(a)(2)(v)				73.71(c)										
			20.405(a)(1)(ii)				50.38(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)(iii)				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																			
Bryan Ford, Compliance Engineer										AREA CODE 3 0 5 2 4 6 - 6 5 9 0																			
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																													
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS																			
SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)																			
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)										<input checked="" type="checkbox"/> NO																			

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

On April 12, 1989, at approximately 1140, with Unit 4 in cold shutdown, a Reactor Control Operator (RCO) was attempting to release a clearance on the Unit 4 Safeguards racks' power fuses. When the RCO installed fuses FU3 and FU4, he returned the power to the "A" train Safety Injection (SI) logic generating an SI signal. The SI signal resulted in the autostarting of the "3A" and "4A" High Head Safety Injection pumps, the "4A" Intake Cooling Water pump, and the "A" Emergency Diesel Generator. All other "A" train systems were either already running, racked out, or in OFF or STOP. The cause of this event was cognitive personnel error by licensed utility personnel. The RCO responsible for writing the clearance did not provide sufficient instructions to prevent the safety system actuations. Corrective actions for this event included adding to the standard clearance in the Plant Clearance Order Network the instruction to use procedure 3/4-ONOP-049 when releasing clearances on these fuses, placing a sign in the Safeguards racks of both units with the caution to use procedure 3/4-ONOP-049 when replacing these fuses, and placing this same caution at the power supply breakers for the SI logic in both units by June 30, 1989. Also, this LER will be included in the required reading for all licensed personnel.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Turkey Point Unit 4	0 5 0 0 0 2 5 1	8 9	— 0 0 2	— 0 0	0 2	OF	0 3

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

DESCRIPTION OF THE EVENT

On April 12, 1989, at approximately 1140, with Unit 4 in cold shutdown, a Reactor Control Operator (RCO, licensed utility personnel) was attempting to release a clearance on the Unit 4 Safeguards racks' power fuses. When the RCO installed fuses FU3 and FU4, he returned power to the "A" train Safety Injection (SI - EIIS:JE) logic. When the power was returned an SI signal was generated, due to low Pressurizer pressure and high steam line differential pressure caused by the unit's shutdown condition. Before the SI logic was de-energized, this signal had been manually blocked. This manual block was automatically removed by the de-energizing of the circuit. The SI signal resulted in the autostarting of the "3A" and "4A" High Head Safety Injection (HHSI - EIIS:BQ) pumps, the "4A" Intake Cooling Water (ICW - EIIS:BS) pump, and the "A" Emergency Diesel Generator (EDG - EIIS:EK), and positioned valves required for correct system emergency alignment per design. All other "A" train equipment was either already operating, racked out, or in OFF or STOP. The unit was returned to its pre-SI signal status by 1242.

CAUSE OF THE EVENT

The cause of this event was cognitive personnel error by licensed utility personnel. The RCO responsible for writing the clearance steps did not provide sufficient instructions to prevent the safety system actuations. Also, the RCO's supervising Senior Reactor Control Operator (SRCO) did not recognize the impact of this activity. The clearance should have specified that procedure 4-ONOP-049, "Re-energizing Safeguards Racks After Loss of Single Power Supply," be used to replace these fuses. This procedure would have prevented the SI signal from being generated by requiring the manual block buttons be held in while replacing these fuses. This would have insured that the manual block was present when the power to the SI logic was returned. Even though the method for restoring power without generating an SI signal is covered by plant procedure, this is an infrequently performed operation.

ANALYSIS

The SI signal was generated by the Pressurizer's low pressure and high steam line differential pressure due to the unit's shutdown condition and all equipment responded as per design. Based on the above, this event had no effect on the public health and safety.



## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Turkey Point Unit 4	0 5 0 0 0 2 5 1	8 9	0 0 2	0 0	0 3	OF	0 3

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

CORRECTIVE ACTIONS

- 1) The instruction to use procedure 3/4-ONOP-049 when releasing clearances on these fuses was added to the standard clearance in the Plant Clearance Order Network (PCON). PCON is a computer system used to assist in the initiation, control, and maintenance of clearances.
- 2) A sign was posted in the Safeguards racks of both units. This sign states that installing fuses FU4 or FU3 may result in an SI signal being generated and to use procedure 3/4-ONOP-049 to install either fuse FU4 or FU3.
- 3) The closing of the power supply breaker can also result in an SI signal being generated. Therefore, a caution will also be placed at supply breaker in both trains for both units. This action will be completed by June 30, 1989.
- 4) This LER will be included in the licensed personnel's required reading.

ADDITIONAL INFORMATION

Similar events: LER 251-88-02 describes a similar event.



MAY 10 1989

L-89-177  
10 CFR 50.73


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

Gentlemen:

Re: Turkey Point Unit 4  
Docket Nos. 50-251  
Reportable Event: 89-02  
Date of Event: April 12, 1989  
"A" Train Safeguards Actuation Due to Personnel Error  
While Installing Fuses in Safeguards Rack

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

For Acting Senior Vice President - Nuclear

COW/JRH/gp

Attachment

cc: Stewart D. Ebnetter, Regional Administrator, Region II, USNRC  
Senior Resident Inspector, USNRC, Turkey Point Plant