

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:89062103 DOC.DATE: 89/06/13 NO. RIZED: NO DOCKET #
 FACIL:50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 AUTH.NAME AUTHOR AFFILIATION
 FORD,B. Florida Power & Light Co.
 WOODY,C.O. Florida Power & Light Co.
 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-029-01:on 881121,RHR isolation & short circuit
 occurred due to personnel error.

W/8 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 4
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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	NRR/DEST/ICSB 7	1 1	NRR/DEST/MEB 9H	1 1
	NRR/DEST/MTB 9H	1 1	NRR/DEST/PSB 8D	1 1
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JUNE 13 1989

L-89-209
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 3
Docket Nos. 50-250
Reportable Event: 88-29 - Revision 1
Date of Event: November 21, 1988
Personnel Error Results in Short Circuit
and Isolation of Residual Heat Removal

The attached Licensee Event Report Revision is being submitted pursuant to the requirements of 10 CFR 50.73 to provide an update on the subject event.

Very truly yours,



C. O. Woody

Acting Senior Vice President - Nuclear

COW/JRH/cm

Attachment

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

8906210319 890613
PDR ADOCK 05000250
S PNU

IF 22
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Turkey Point Unit 3										DOCKET NUMBER (2) 0 5 0 0 0 2 5 0					PAGE (3) 1 OF 0 3	
TITLE (4) Personnel Error Results in Short Circuit and Isolation of Residual Heat Removal for Approximately Five Minutes																
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 5 0 0 0			
11	21	88	88	029	01								0 5 0 0 0			
OPERATING MODE (9) 5		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)				50.38(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)(ii)				50.73(a)(2)(viii)(B)						
		20.405(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)						
LICENSEE CONTACT FOR THIS LER (12)																
NAME Bryan Ford, Compliance Engineer										TELEPHONE NUMBER 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 NPDs		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDs						
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 November 21, 1988, at 1120, with Unit 3 in cold shutdown, an Instrument and Control (I&C) specialist was performing a channel calibration of the Boric Acid Storage Tank (BAST) level instrumentation. While connecting a digital multimeter in Hagan process control rack 3-QR-6, the specialist accidentally short-circuited the power terminal lead, which resulted in the closure of Residual Heat Removal (RHR) suction isolation valve MOV-3-750. The closure of MOV-3-750 resulted in a loss of RHR flow to the Unit 3 core. At 1121 the Reactor Control Operator (RCO) stopped the operating 3A RHR pump. At 1122 the RCO opened valve MOV-3-750. At 1125 the RCO started the 3A RHR pump, restoring RHR flow. The event was caused by personnel error in that the I&C specialist used improper methods to connect test equipment to the BAST level instrumentation. Following the event, I&C shift personnel were briefed on the error and the proper method of connecting test equipment. This event has been incorporated into the I&C specialist's training to emphasize to personnel the importance of properly connecting test equipment. Also, the possibility of defeating the RCS high pressure interlock during reduced inventory conditions is being evaluated as part of the actions being taken in response to Generic Letter 88-17.

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 3	05000250	88	029	01	02	OF	03

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

DESCRIPTION OF THE EVENT

On November 21, 1988, at 1120, with Unit 3 in cold shutdown, an Instrument and Control (I&C) specialist was performing a channel calibration of the Boric Acid Storage Tank (BAST) level instrumentation. While connecting a digital multimeter in Hagan process control rack 3-QR-6, the specialist accidentally short-circuited the power terminal lead which caused breaker 3P06-5 to open. The opening of breaker 3P06-5 de-energized, among other equipment, pressure controller PC-3-403. PC-3-403 provides the Reactor Coolant System (RCS) high pressure interlock for Residual Heat Removal (RHR) suction isolation valve MOV-3-750. When PC-3-403 was de-energized, it gave a high RCS pressure signal, causing MOV-3-750 to close. At Turkey Point Unit 3, a single suction line from the "C" hot leg provides suction for both RHR pumps. Therefore, the closure of MOV-3-750 resulted in a loss of RHR flow to the Unit 3 core. At 1121 the Reactor Control Operator (RCO) stopped the operating 3A RHR pump, in accordance with plant procedures. At 1122 the RCO reset breaker 3P06-5 and opened valve MOV-3-750. At 1125 the RCO started the 3A RHR pump, restoring RHR flow.

CAUSE OF THE EVENT

The event was caused by personnel error in that the I&C Specialist used improper methods to connect test equipment to the BAST level instrumentation which resulted in short-circuiting the power terminal.

ANALYSIS

The closure of valve MOV-3-750 resulted in a loss of RHR flow to the Unit 3 core. However, flow was restored within approximately five minutes of the valve closure. During the period of time without RHR flow, there was no appreciable increase in RCS temperature. Based on the above, the health and safety of the public was not affected.

CORRECTIVE ACTIONS

- 1) The RHR pump was stopped, MOV-3-750 was reopened and the RHR pump restarted within approximately five minutes.
- 2) I&C shift personnel were briefed on the error that occurred and the proper method to connect test equipment.

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 3	0 5 0 0 0 2 5 0	8 8	— 0 2 9	— 0 1	0 3	OF	0 3

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

- 3) This event was incorporated into the I&C specialist's training to emphasize to personnel the importance of properly connecting test equipment.
- 4) The possibility of defeating the RCS high pressure interlocks under reduced inventory conditions is being evaluated as part of the actions being taken in response to Generic Letter 88-17. Defeating the interlocks under non-reduced inventory conditions has been evaluated. It was found not to be desirable considering the amount of time available to restore RHR flow.

ADDITIONAL INFORMATION

Similar events: LER 251-86-06 describes a similar event.



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