

ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:8901030388 DOC.DATE: 88/12/30 NOTARIZED: NO DOCKET #
 FACIL:50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 AUTH.NAME AUTHOR AFFILIATION
 LYONS,E. Florida Power & Light Co.
 CONWAY,W.F. Florida Power & Light Co.
 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-032-00:on 881202, personnel error results in loss of
 power to vital instrument bus & isolation of CR & CV.
 W/8 ltr.

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11/14/88

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 03											
TITLE (4) Personnel Error Results in Loss of Power to Vital Instrument Bus and Automatic Isolation of Control Room and Containment Ventilation																										
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)													
1	2	0	2	8	8	8	8	0	3	2	0	1	2	3	0	8	8	Turkey Point Unit 4	0	5	0	0	0	2	5	1
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)				<input checked="" type="checkbox"/> 50.73(a)(2)(iv)				73.71(b)											
			20.405(a)(1)(i)				50.36(c)(1)				<input type="checkbox"/> 50.73(a)(2)(v)				73.71(c)											
			20.405(a)(1)(ii)				50.36(c)(2)				<input type="checkbox"/> 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)				<input type="checkbox"/> 50.73(a)(2)(viii)(A)															
			20.405(a)(1)(iv)				50.73(a)(2)(ii)				<input type="checkbox"/> 50.73(a)(2)(viii)(B)															
			20.405(a)(1)(v)				50.73(a)(2)(iii)				<input type="checkbox"/> 50.73(a)(2)(ix)															
LICENSEE CONTACT FOR THIS LER (12)																										
NAME Edward Lyons, Compliance Engineer										TELEPHONE NUMBER																
										AREA CODE 3 0 5 2 4 6 - 6 7 3 1																
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										
<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 December 2, 1988, at 0500, with Unit 3 in cold shutdown and Unit 4 defueled, a Nuclear Turbine Operator (NTO) was attempting to remove the 4B normal inverter from service to allow maintenance to be performed. After transferring load to the "B" spare inverter, the NTO mistakenly opened the output breaker for the "B" spare inverter instead of opening the output breaker for the 4B normal inverter. This resulted in a loss of power to the 120 vital AC bus 4P08 and the process radiation monitoring rack. Loss of the process radiation monitoring rack resulted in the automatic isolation of the Containment Ventilation and Control Room Ventilation systems. The breaker was closed approximately 30 seconds after being opened, and at 0540 the Control Room Ventilation system was returned to its normal alignment. The cause of the event was personnel error in that the NTO opened the output breaker for the "B" spare inverter instead of opening the output breaker for the 4B normal inverter. Human factors considerations contributed to this event in that the "B" spare inverter was mis-labeled as "B standby inverter." The NTO was counseled following the event. The spare inverters will be re-labeled as spare inverters. In addition, the procedure in use at the time of the event will be revised to require that the operator verify that the inverter to be de-energized is not supplying power to the bus.

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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 3 2	0 0	0 2	OF	0 3

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

DESCRIPTION OF THE EVENT

On December 2, 1988, at 0500, with Unit 3 in cold shutdown and Unit 4 defueled, a Nuclear Turbine Operator (NTO) (non-licensed utility employee) was attempting to remove the 4B normal inverter (EIIS:EF; component: INVT) from service to allow maintenance to be performed. The NTO had previously transferred the load from the 4B normal inverter to the "B" spare inverter. Following the load transfer, the NTO mistakenly opened the output breaker for the "B" spare inverter, instead of opening the output breaker for the 4B normal inverter. This resulted in a loss of power to the 120 volt AC vital bus 4P08. The process radiation monitoring rack is powered from bus 4P08. Therefore, the loss of bus 4P08 resulted in the loss of the process radiation monitoring rack. The loss of the process radiation monitoring rack resulted in the automatic isolation of the Containment Ventilation System (EIIS:VA) and the Control Room Ventilation System (EIIS:VI). Breaker 4P08 was reclosed approximately 30 seconds after being opened. At 0515 the 4B normal inverter was de-energized. At 0540, the Control Room Ventilation System was returned to its normal configuration.

CAUSE OF THE EVENT

The cause of the event was personnel error in that the NTO opened the output breaker for the "B" spare inverter instead of the output breaker for the 4B normal inverter. Human factors considerations contributed to the cause of this event. The section of the procedure used to de-energize an inverter is labeled "De-energizing a Standby Inverter." The procedure requires that the operator "Perform the following steps at the affected inverter panel." In this event, the affected inverter was the 4B normal inverter. In addition, the "B" spare inverter was mis-labeled as "B Standby Inverter." The NTO apparently became confused about which inverter was the "affected inverter" and opened the wrong breaker.

ANALYSIS

The Containment Ventilation System and the Control Room Ventilation System isolated as designed on a loss of power to the process radiation monitoring rack. No plant equipment was damaged as a result of this event. Based on the above, this event had no effect on the health and safety of the public.

CORRECTIVE ACTIONS

- 1) Breaker 4P08 was reclosed, within approximately 30 seconds, restoring power to the bus.
- 2) The NTO and the other operators on the same shift were counseled on the importance of recognizing the goals of the evolution being performed, and the relationship between those goals and the procedural steps being performed. In addition, a night order was issued to instruct all shifts to verify that an inverter being removed from service is not carrying any load prior to opening the output breaker.

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 3 2	0 0	0 3	OF	0 3	

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

- 3) The spare inverters will be re-labeled as spare inverters. This action will be completed by February 24, 1989.
- 4) Procedure O-OP-003.3 will be revised to require that the operator verify that the inverter to be de-energized is not supplying power by checking the associated ammeter prior to opening the breakers. This action will be completed by February 10, 1989.

ADDITIONAL INFORMATION

Similar events: LERs 251-88-002 and 250-87-032 describe similar events.



FPL

P.O. Box 14000, Juno Beach, FL 33408-0420

DECEMBER 30 1988

L-88-555
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Units 3 and 4
Docket Nos. 50-250 and 50-251
Reportable Event: 250-88-32
Date of Event: December 2, 1988
Personnel Error Results in Loss of Power
to Vital Instrument Bus and Automatic
Isolation of Control Room and Containment Ventilation

The attached License Event Report (LER) is being submitted pursuant to the requirements of 10 CFR 50.73 to provide notification of the subject event.

Very truly yours,

W. F. Conway
Senior Vice President - Nuclear

WFC/RHF/gp

Attachment

cc: Malcolm L. Ernst, Acting Regional Administrator, Region II,
USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

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11