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FACIL:50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
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SUBJECT: LER 89-011-00:on 890617,two safeguards actuations due to personnel error.

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JULY 17 1989

L-89-257
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 3
Docket No. 50-250
Reportable Event: 89-11
Date of Event: June 17, 1989
Two Safeguards Actuations due to Personnel Error

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
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

8907250146 890717
PDR ADOCK 05000250
S PDC

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
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TITLE (4)
Two Safeguards actuations due to Personnel Error

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 6	1 7	8 9	8 9	0 1 1	0 0	0 7	1 7	8 9		0 5 0 0 0 0
										0 5 0 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)									
	20.402(b)		20.406(c)		<input checked="" type="checkbox"/> 50.73(a)(2)(iv)		73.71(b)			
POWER LEVEL (10) 0 0 0	20.406(a)(1)(i)		50.38(a)(1)		50.73(a)(2)(v)		73.71(c)			
	20.406(a)(1)(ii)		50.38(a)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 368A)			
	20.406(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)					
	20.406(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)					
	20.406(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 NPDOS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	

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 June 16, 1989, with Unit 3 in mode 5, the "A" train safeguards logic was being re-energized. At approximately 1613, when the manual block buttons were released, in accordance with procedure, an "A" train Safety Injection (SI) signal was produced. The Instrument and Controls technicians investigating the event identified and replaced two switch contact blocks which showed signs of physical damage. These damaged switch contact blocks were considered to be the cause of the actuation. Activities to return power to the safeguard logic were resumed, this time starting with the "B" safeguards train. At approximately 2149, when the manual block buttons were released a "B" train SI signal was produced. The root cause of this event is personnel error by non-licensed utility personnel. Approximately one month prior to these events, a new label was installed on the Safety Injection Block switch with the "blocked" and "unblocked" positions reversed. This resulted in the switch being in the "unblocked" position instead of the "blocked" position when the manual block buttons were released. Corrective actions for this event include counseling involved personnel, replacing the incorrect label, revising procedure O-ADM-209, Equipment Tagging and Labeling, and revising drawing 5610-M-430-171 sheet 5.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)

Turkey Point Unit 3

DOCKET NUMBER (2)

0 5 0 0 0 2 5 0

LER NUMBER (8)

YEAR

8 9

SEQUENTIAL

0 1 1

REVISION

0 0

PAGE (3)

0 2 OF 0 3

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

EVENT

On June 16, 1989, with Unit 3 in cold shutdown (mode 5), the Unit 3 safeguards logic (EIIS:JE) was being re-energized in preparation for restarting the unit. To accomplish this the "A" train safeguards logic was being re-energized by performing procedure 3-ONOP-049, "Re-energizing Safeguards Racks after Loss of Single Power Supply." As required by the procedure, the Safety Injection Block switch was placed in the "blocked" position and the manual block buttons were depressed. The fuses were then installed restoring power to the logic. At approximately 1613, when the manual block buttons were released, in accordance with the procedure, an "A" train Safety Injection (SI) signal was produced. All equipment responded as expected and no injection into the core resulted from the SI signal. Equipment was subsequently returned to standby condition. Maintenance, Instrument and Controls (I&C) section, was contacted to investigate the cause of the actuation. The I&C technician investigating identified and replaced two switch contact blocks which showed signs of physical damage. These damaged switch contact blocks were considered to be the cause of the actuation.

Activities to return power to the safeguards logic were resumed, this time starting with the "B" safeguards train. The Safety Injection Block switch was placed in the "blocked" position, and the manual block buttons were depressed. The fuses were then installed restoring power to the logic. At approximately 2149, when the manual block buttons were released, a "B" train SI signal was produced. All equipment responded as expected, and no injection into the core resulted from the SI signal. Equipment was subsequently returned to the standby condition.

CAUSE OF THE EVENT

The root cause of this event was personnel error by non-licensed utility personnel. The label on the Safety Injection Block switch had been recently replaced with a label which contained more detailed information. Both the person responsible for validating the label and the person who installed the label for the Safety Injection Block switch failed to adequately validate that all the information contained on the new label was correct. The new label installed at the switch had the "blocked" and "unblocked" switch positions reversed. This resulted in the switch being placed unknowingly in the "unblocked" position instead of the "blocked" position. With the switch in the "unblocked" position, when the manual block buttons were released, an SI signal was produced. The exact date that the new label was installed is unknown. It is known that the old label, with the correct information, was in place in March 1989. Discussions with the person who installed the new label has determined that the new label was installed after the unit was shutdown approximately one month prior to this event.

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	89	011	00	03	OF	03

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

The reason that the inaccurate label was not identified following the first SI actuation was an unclear drawing. The I&C technician was required by the Plant Work Order for this activity to verify that the switch had proper continuity in the block, neutral, and unblock positions. When he performed this step, confusing information on drawing 5610-M-430-171 sheet 5, Units 3 & 4 Safeguards System, lead the technician to believe that the switch was responding correctly. This resulted in the damaged switch contact blocks being considered the cause of the first actuation and the inaccurate label not being identified.

ANALYSIS

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

CORRECTIVE ACTIONS

- 1) The Unit 3 Safety Injection Block switch was relabeled to correctly identify switch positions.
- 2) The Safety Injection Block switch labels in the Simulator and Unit 4 were verified to be correct.
- 3) The person responsible for validating the tag, and the person responsible for placing the tag were counseled. This counseling stressed the importance of verifying all of the information contained on tags before they are installed.
- 4) A revision to procedure O-ADM-209, "Equipment Tagging and Labeling," has been approved. The revised procedure requires independent verification by a Reactor Control Operator of the accuracy of all information on tags being installed in the control room.
- 5) The revision to drawing 5610-M-430-171 sheet 5 to remove the confusion about switch response will be revised by August 15, 1989.

ADDITIONAL INFORMATION

LER 250-89-002 describes a previous similar event.