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ACCESSION NBR:8907280112 DOC.DATE: 89/07/17 NOTARIZED: NO DOCKET #
FACIL:50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
AUTH.NAME AUTHOR AFFILIATION
DAY,S.T. Florida Power & Light Co.
WOODY,C.O. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 89--10-00:on 890616,overloaded breaker results in loss of power to vital instrument rack & automatic isolation. W/8 ltr.

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

JULY 17 1989

L-89-258
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: 89-10
Date of Event: June 16, 1989
Overloaded Breaker Results in Loss of Power to Vital Instrument Rack and Automatic Isolation of Control Room and Containment Ventilation

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,

R. J. Acosta for
C. O. Woody
Acting Senior Vice President - Nuclear

COW/JRH/cm

Attachment

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

IE22
1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Turkey Point Unit 3	0 5 0 0 0 2 5 0	1 OF 0 3

TITLE (4) Overloaded Breaker Results in Loss of Power to Vital Instrument Rack 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)
0 6	1 6	8 9	8 9	- 1 0	0 0	0 7	1 7	8 9	Turkey Point Unit 4	0 5 0 0 0 2 5 1
										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)	X 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)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Stanley T. Day, Jr. - 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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

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 June 16, 1989, at 1115, with Unit 3 in Cold Shutdown and Unit 4 in Startup (Mode 2 at 2% power), Instrumentation and Control personnel plugged an oscilloscope into a convenience receptacle located in Rack No. 67. Upon energizing the oscilloscope, a breaker supplying vital A/C to process radiation monitoring (PRM) rack No. 66 tripped. This resulted in the loss of power to the rack No. 66, and automatic isolation of the Containment Ventilation and Control Room Ventilation systems. The breaker was closed at approximately 1122, and the control room ventilation system was returned to its normal alignment at approximately 1205. The cause of the event appears to be overloading of breaker 3P08-19. An engineering package has been prepared that will provide the PRMS rack with an appropriately sized vital A/C power source. The subject receptacle has been removed from service. A clearance tag has been taped across the A/C outlet to render it unusable, and the tag states "Do not use this receptacle." The oscilloscope's wiring was confirmed to be correct. A study will be conducted to identify other receptacles powered by vital A/C, and to determine if determinating or rewiring to another power source is appropriate.

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 9	— 0 1 0	— 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 June 16, 1989, at approximately 1115, with Unit 3 in Cold Shutdown (Mode 5), and Unit 4 in Startup (Mode 2 at 2% power), Instrumentation and Control personnel (non-licensed utility personnel) plugged an oscilloscope into a convenience receptacle located in Rack No. 67 to verify background readings on the Pressurizer Safety Valve (EIIS:AB) acoustic monitor. This convenience receptacle is powered by a vital A/C breaker (3P08-19). This breaker also provides power to Process Radiation Monitoring rack No. 66. Upon energizing the oscilloscope, breaker 3P08-19 (EIIS:EF) tripped. This de-energized Process Radiation Monitoring Rack No. 66, resulting in automatic isolation of the Control Room Ventilation (EIIS:VI), and Containment Ventilation Systems (EIIS:VA). At approximately 1122, breaker 3P08-19 was closed. The Control Room Ventilation System was returned to normal at approximately 1205.

CAUSE OF THE EVENT

The cause of the event was an overloaded breaker. A measurement of the normal breaker amperage was performed, it was 3.7 amps. The oscilloscope's inrush current was measured to be 9.2 amps. The subject breaker size is 10 amps. Prior to energizing the oscilloscope, the subject equipment and components were functioning properly. Once the oscilloscope was turned on, breaker 3P08-19 tripped, and the Process Radiation Monitoring rack was de-energized.

ANALYSIS

The Containment Ventilation and The Control Room Ventilation Systems isolated as designed on a loss of power to the Process Radiation Monitoring Rack No. 66. 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) An engineering package has been written to provide the PRMS rack with a vital A/C source that is more appropriate. This will be implemented in accordance with the Integrated Schedule.

2) The subject receptacle has been removed from service. A clearance tag has been taped across the subject A/C receptacle to render the outlet unusable, the tag states "Do not use this receptacle."

FACILITY NAME (1)	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)

3) The oscilloscope's wiring was thoroughly checked, and was found to be correct.

4) A study will be conducted to identify other receptacles powered by vital A/C, and to determine if determinating or rewiring to another source is appropriate. This action will be completed by September 1, 1989.

ADDITIONAL INFORMATION

Similar Events: Although resulting from different root causes, the following events resulted in automatic isolation of the Containment Ventilation and Control Room Ventilation Systems LER 250-88-032, 250-88-010, 250-88-003, 251-88-006, and 251-88-002.