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SUBJECT: LER 90-006-00:on 900406,isolation of CRV sys following loss of power on channel RAI-6642 due to personnel error.
W/9 ltr.

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MAY 07 1990

L-90-169
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Units 3 & 4
Docket No. 50-250
Reportable Event: 90-006
Date of Event: April 6, 1990
Isolation of Control Room Ventilation System Following Loss of Power on Channel RAI-6642 Due to Personnel Error

The attached Licensee Event Report is being provided pursuant to the requirements of 10 CFR 50.73 for notification of the subject event.

Very truly yours,

K. N. Harris
Vice President
Turkey Point Plant Nuclear

KNH/DRP/MKA/mka

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) Isolation of Control Room Ventilation System Following Loss of Power on Channel RAI-6642 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 4	0 6	9 0	9 0	0 0 6	0 0	0 5	0 7	9 0	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
David R. Powell, Licensing Superintendent	AREA CODE 3 0 5 — 2 4 6 - 6 5 5 9

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 April 6, 1990, at 1446 EDT, with Unit 3 in mode 5 (cold shutdown) and Unit 4 in mode 1 (power operation), the control room ventilation system for the common control room of Units 3 and 4 tripped while performing plant procedure TP-584, "Control Room HVAC Radiation Monitor RAI 6642 and RAI 6643 Channel Calibration." At 1547 EDT, the NRC was notified of the event in accordance with 10CFR50.72. The existing RP-1A module for channel RAI-6642 had a faulty power available indicator and was being replaced with a new module. Although the indicator did not work the module did function properly. In order to remove the old module, power to it had to be de-energized. Two power supply fuses located in the power supply powering channel RAI-6642's RP-1A module were removed resulting in the control room ventilation system tripping. The control room ventilation system changed from normal circulation flow mode to recirculation flow mode. The event was caused by personnel error in that the I&C specialist didn't follow plant procedure TP-584 from the beginning and when he encountered a conflict with the procedure and the as-found plant conditions, he failed to stop and inform the field supervisor. The responsible individual was counselled on the importance of stopping when a procedural step is encountered which conflicts with the as-found condition of the plant equipment.

I DESCRIPTION OF EVENT

On April 6, 1990, at 1446 EDT, the control room ventilation system (EIIS:JE) for Units 3 and 4 tripped resulting in the control room air switching from the normal flow mode to the recirculation flow mode. Unit 3 was in cold shutdown (mode 5) while Unit 4 was in mode 1 running at 100% power. In the normal flow mode, the control room receives air from the outside. In the recirculation mode, the control room is isolated from the outside air but the air conditioning or heating system will continue to operate and recirculate the control room air. The heating, ventilation and air conditioning (HVAC) trip occurred during the performance of temporary plant procedure TP-584, "Control Room HVAC Radiation Monitor RAI 6642 and RAI 6643 Channel Calibration."

Two days earlier, plant procedure TP-584 had been worked under a plant work order to remove and calibrate the radiation detector for channel RAI-6642. Prior to removal of the detector, the HVAC system was tripped and the channel was disabled by lifting a wire in accordance with TP-584. Upon completion of a satisfactory calibration, the detector was reinstalled. Channel RAI-6642 was re-enabled by restoring the lifted wire lead and the HVAC was returned to its normal line up. After this, readout module RP-1A, which is located in the control room, was found to have a faulty power available indicator. Even though the light failed to work the module did function properly. At this point, the decision was made to replace the defective module with a new module.

On April 6, 1990, the replacement module arrived and was calibrated in the shop in accordance with steps 6.3.3 through 6.3.45 of plant procedure TP-584. An I&C Specialist was tasked with installing the new module. The procedure was resumed at step 6.3.46. The RP-1A module was transported to the control room in accordance with step 6.3.46. After reviewing the second half of the step which requires installing the module in the rack and the next series of steps to be performed, the I&C specialist realized that the procedure did not address removing the old module. Step 6.3.47 for example, installs two fuses in power supply RP-23. Power supply RP-23 supplies a positive and negative 24 volts direct current (VDC) to module RP-1A. Performance of step 6.3.47 was not possible due to the power supply already having fuses installed. Instead of stopping at this point to confer with the field supervisor, the I&C specialist attempted to remove the existing RP-1A module by performing steps out of sequence. Step 6.3.1 was performed next which removed the two fuses installed in power supply RP-23. Removal of these fuses de-energized the module to allow its removal. As soon as the fuses were removed, the control room ventilation system shifted into the recirculation mode.

On April 6, 1990 at 1547 EDT, a 50.72(b)(2)(ii) notification of the incident was made to the NRC to report this occurrence.

II CAUSE OF EVENT

The primary cause of this event was the plant I&C specialist failing to comply with plant procedure 0-ADM-715, "Maintenance Procedure Usage," step 5.1.1. The specialist failed to start at the beginning of the procedure and he jumped from step 6.3.46 to step 6.3.1 of procedure TP-584 without receiving approval to do so from the field supervisor. These actions did not meet step 5.1.1 of procedure 0-ADM-715 which requires maintenance procedures be followed in a step by step manner. Preforming steps out of sequence is allowed provided the procedure allows it and applicable steps have been marked by the field supervisor.

III ANALYSIS OF EVENT

During performance of TP-584, the control room ventilation system tripped unexpectedly. Control room ventilation Technical Specification 3.4.6 is classified as an engineered safety feature (ESF). Since the control room ventilation system is considered an ESF, this event is reportable under the requirements of 10CFR 50.73(a)(2)(iv).

Upon loss of power to module RP-1A, the control room ventilation system isolated per design. This action was expected to occur under these conditions and was not a result of a valid signal from the radiation monitor channels. No radiation releases occurred during this event. Based on the above, the health and safety of the public was not affected.

IV CORRECTIVE ACTIONS

1) The I&C specialist was counselled on the importance of stopping a procedure when procedural steps conflict with the found condition of the plant or equipment. This action was completed on April 7, 1990.

2) Procedure usage guidelines were reviewed during the I&C department shop meeting to stress the importance of stopping a procedure when procedural steps conflict with the found conditions of the plant. This was completed on May 4, 1990.

V ADDITIONAL INFORMATION

Module RP-1A, power supply RP-23 and the model RD-1 gamma radiation detector are manufactured by General Atomics Tech.

A similar occurrence was reported in LER 251-88-002-00. The cause of the event identified in LER 251-88-002-00 is different from the subject LER.