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FACIL:50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
AUTH.NAME AUTHOR AFFILIATION
POWELL,D.R. Florida Power & Light Co.
PLUNKETT,T.F. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-004-02:on 910720,containment isolation signal generated when fuse was installed in containment isolation relay rack.Caused by using inadequate procedure.Revised procedures.W/910819 ltr.

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

AUG 19 1991

L-91-218A
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 4
Docket No. 50-251
Reportable Event: 91-004-00
Date of Event: July 20, 1991
Inadvertent Phase A Containment Isolation due to Inadequate Procedure

The attached Licensee Event Report 251-91-004-00 is being provided in accordance with the requirements of 10 CFR 50.73 (a)(2)(iv) to provide notification of the subject event.

Very truly yours,

T. F. Plunkett
Vice President
Turkey Point Nuclear

TFP/CLM/cm

enclosures

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

IE22 1/1

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
TURKEY POINT UNIT 4	05000251	1 OF 3

TITLE (4) INADVERTENT PHASE A CONTAINMENT ISOLATION DUE TO INADEQUATE PROCEDURE

EVENT DATE (5)			LER NUMBER (6)			RPT DATE (7)			OTHER FACILITIES INV. (8)	
MON	DAY	YR	YR	SEQ #	R#	MON	DAY	YR	NAME	DOCKET # (S)
07	20	91	91	004	00	08	19	91		

OPERATING MODE (9)	N
POWER LEVEL (10)	000

10 CFR 50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER (12)

David R. Powell, Superintendent of Licensing	TELEPHONE NUMBER: 305-246-6559

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	NPRDS?	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	NPRDS?

SUPPLEMENTAL REPORT EXPECTED (14) NO ☒ YES ☐ (if yes, complete EXPECTED SUBMISSION DATE)	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (16)

At 1407 on July 20, 1991, with both units shut down and defueled, a partial Engineered Safety Feature (ESF) actuation occurred. A Phase A Containment Isolation signal on Train A was generated when a fuse was installed in a Containment Isolation relay rack. Due to the configuration of the plant, only three automatic actions occurred. This event was caused by licensed operators using an inadequate procedure. Corrective actions include revision of the procedure, verification of safeguards relay positions, and awareness training of plant personnel.

I. EVENT DESCRIPTION

At 1407 on July 20, 1991, with both units shut down and defueled, a partial Engineered Safety Feature (ESF) actuation was inadvertently initiated [EIIS:JE]. Plant personnel were re-energizing ESF equipment in preparation for an Integrated Safeguards Test, using the restoration section of Temporary Procedure TP-688, "Defeating Engineered Safety Feature (ESF) Equipment." When fuse FU2 was installed in Containment Isolation relay rack QR50, a Train A Phase A Containment Isolation was generated [EIIS:JM]. Due to the configuration of the plant, only three automatic actions occurred:

1) 4A and 4C Normal Containment Coolers tripped [EIIS:BK;component:CLR]

2) MOV-4-1417, Component cooling Water to the Normal Containment Coolers, closed [EIIS:CC;component:ISV]

3) CV-4-2821, Containment Sump pump discharge valve, closed [EIIS:WK;component ISV]

At 1500 on July 20, 1991, FPL notified the NRC Operations Center of a significant event in accordance with 10CFR50.72(b)(2)(ii).

II. EVENT CAUSE

This event was caused by licensed operators using an inadequate procedure.

Relay SIA1 was found in the tripped or actuated position. SIA1 is the relay which actuates a Train A Phase A isolation upon receipt of a Safety Injection signal. No Safety Injection signal was present at the time. Relay SIA1 is one of twelve Westinghouse MG-6 relays which were replaced in accordance with Plant Change/Modification (PC/M) package 89-586 during this outage. We believe that the new replacement relay was installed in the tripped condition.

The PC/M specified that circuits were to be re-energized using procedure 4-ONOP-049, "Re-energizing Safeguard Racks After Loss of a Single Power Supply." 4-ONOP-049 requires that the relays are verified reset, but it is limited to re-energizing Safeguard Relay Racks QR42, 43, 44, and 45. TP-688 correctly directs operators to use 4-ONOP-049 to re-energize the Safeguard racks, but this step occurs <u>after</u> the Containment Phase A and Phase B racks are re-energized. TP-688 does not require verification that the relays are reset before they are re-energized.

Had the Safeguard racks been re-energized first, or had all relays been verified reset before any were re-energized, this event would not have occurred.

III. EVENT SAFETY ANALYSIS

The three automatic actions had no impact on plant evolutions in progress at the time of the event. The normal containment coolers were not required to be operable, and the containment sump was not being pumped. The event was discovered immediately, and performance of TP-688 was terminated, while investigation and restoration were carried out. Had the unit been operating, relay SIA1 would have been reset by the completion of TP-688, and the event would not have occurred.

Since the event involved an ESF actuation rather than a failure, and since no operable system or component was made inoperable as a result of the event, the health and safety of the public were not adversely affected.

IV. CORRECTIVE ACTIONS

1. Performance of TP-688 and related work activities were stopped until the cause for the actuation was determined.

2. All of the new MG-6 relays in both Units 3 and 4 were inspected to verify they were in the correct position. All were found to be in the correct position.

3. TP-688 has been modified to include the verification of correct relay positions prior to the installation of power fuses in QR50 or QR51.

4. Training Brief No. 329, "Work Controls Awareness," and a special edition of the plant weekly newsletter have been issued to ensure plant personnel are made aware of the necessity for heightened attention to detail in work controls.

V. ADDITIONAL INFORMATION

LER 251-89-002 describes a safeguards actuation due to inadequate controls; one of the corrective actions was to add to the standard clearances in the Plant Clearance Order Network, an instruction to use 3/4-ONOP-049 when installing Safeguards rack fuses (FU3 & FU4).