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 FACIL: 50-251 Turkey Point Plant, Unit 4, Florida Power and Light C 05000251
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 KNORR, J.E. Florida Power & Light Co.
 PLUNKETT, T.F. Florida Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 92-010-00: on 921121, an automatic start of 4B EDG
 occurred during 3B EDG safeguards test. Caused by inadequate
 procedure. Administrative Procedure 0-ADM-501 will be
 revised. W/9211217 ltr.

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DEC 17 1992

L-92-335
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: 92-010-00
Automatic Start of 4B Emergency Diesel Generator

The attached Licensee Event Report 251-92-010-00 is being provided in accordance with 10 CFR 50.73 (a) (2) (iv).

If there are any questions, please contact us.

Very truly yours,

T. F. Plunkett
Vice President
Turkey Point Nuclear

TFP/JEK/jk

enclosure

cc: Stewart D. Ebner, Regional Administrator, Region II,
USNRC
Ross C. Butcher, Senior Resident Inspector, USNRC, Turkey
Point Plant

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)

TURKEY POINT UNIT 4

DOCKET NUMBER (2)

05000251

PAGE (3)

1 OF 3

TITLE (4) Automatic Start of 4B Emergency Diesel Generator

EVENT DATE (5)			LER NUMBER(6)			RPT DATE (7)			OTHER FACILITIES INV. (8)		
MON	DAY	YR	YR	SEQ #	R#	MON	DAY	YR	FACILITY NAMES		DOCKET # (5)
11	21	92	92	010	00	12	17	92	TURKEY POINT UNIT 3		05000250

OPERATING MODE (9) 1

POWER LEVEL (10) 100%

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § 10 CFR 50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER (12)

James E. Knorr, Licensing Engineer

TELEPHONE NUMBER

305-246-6757

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

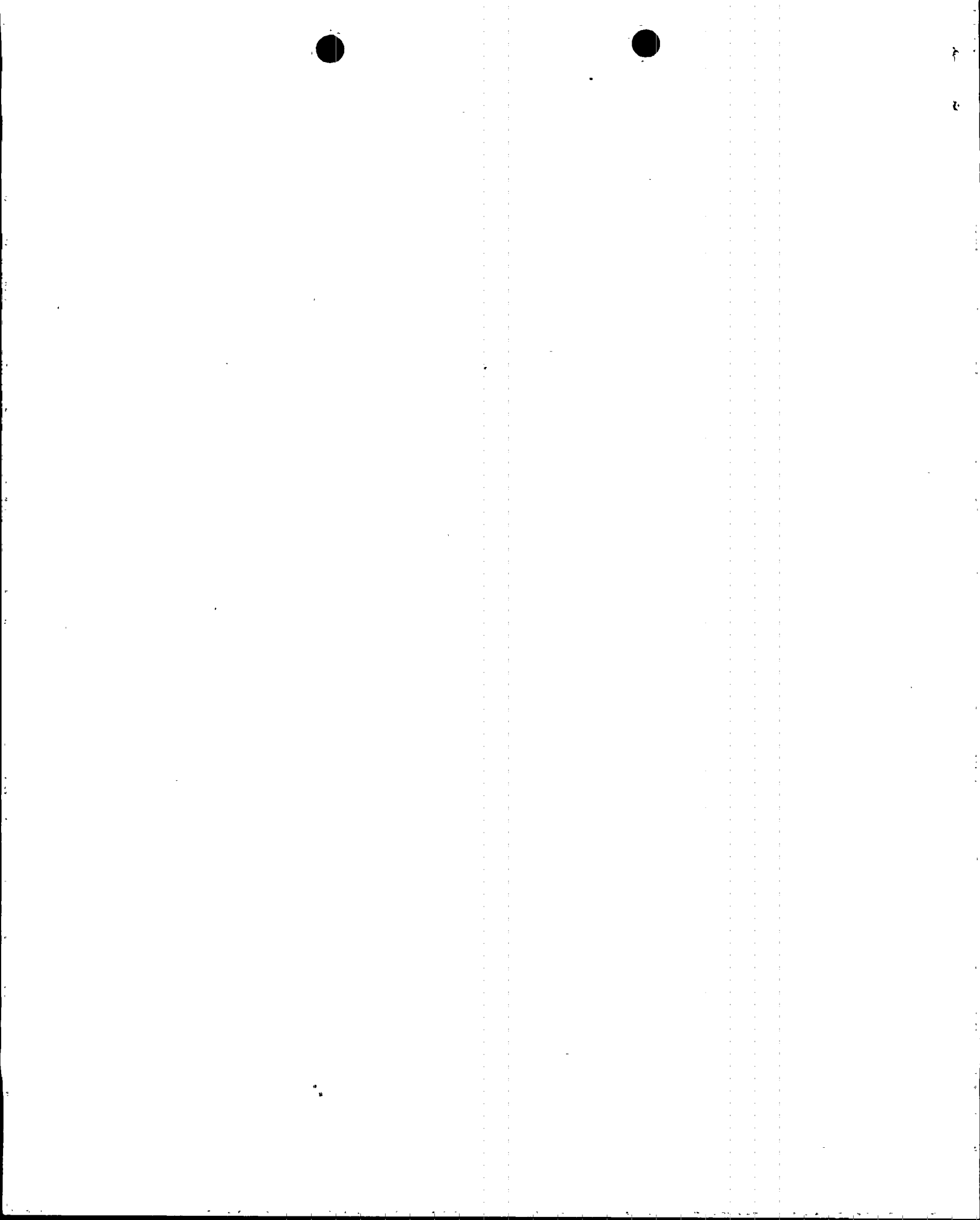
DAY

YEAR

ABSTRACT (16)

On November 21, 1992, at 1412 EST, an automatic start of the 4B emergency diesel generator occurred during the 3B emergency diesel generator safeguards test. During this testing, procedure 3-OSP-203.2, Train B Safeguards Integrated Test, required the lifting of leads to prevent the start of the Unit 4 diesel generators upon the initiation of a safety injection signal on Train "B" of Unit 3. Incorrect leads were lifted, due to an inadequate procedure, resulting in the automatic start of the 4B emergency diesel generator upon the injection of a simulated safety injection signal on Unit 3 Train "B". The lead that was lifted resulted in no unexpected action other than the automatic start of the 4B emergency diesel generator. Therefore, the test of the 3B emergency diesel generator was successful.

Corrective actions require the inclusion of applicable wire numbers for lifted leads in procedures requiring leads to be lifted.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME	DOCKET NUMBER	LER NUMBER	PAGE NO.
TURKEY POINT UNIT 4	05000251	92-010-00	02 OF 03

I. EVENT DESCRIPTION

On November 21, 1992, at 1412 EST, and automatic start of the 4B emergency diesel generator (EIIS-EK) (IEEE-DG) occurred during the 3B emergency diesel generator safeguards test. At Turkey Point, four safety injection pumps (EIIS-BJ) (IEEE-P) are shared between Units 3 and 4. Each safety injection pump is supplied power from its own safeguards bus (EIIS-EB) (IEEE-BU). Therefore, upon a valid or simulated safety injection signal from either unit, all four emergency diesel generators automatically start. During safeguards testing of the 3B emergency diesel generator, test procedure 3-OSP-203.2, Train B Safeguards Integrated Test, required the lifting of leads to prevent the start of the Unit 4 emergency diesel generators upon the injection of a simulated safety injection signal on Train B of Unit 3. The terminal location for the lifted leads was specified; however, the specific lead to be lifted of three leads on the terminal was not specified. The wrong lead was lifted resulting in the 4B emergency diesel generator automatically starting on the injection of a simulated Unit 3 safety injection signal. Given the configuration of the jumpers at the time of the test, the 4B emergency diesel generator started as designed.

This event was reported to the NRC operations center in accordance with 10 CFR 50.72 (b) (2) (ii).

II. EVENT CAUSE

The root cause of the automatic start of the 4B emergency diesel generator was an inadequate procedure. As discussed above, operations surveillance procedure 3-OSP-203.2 did not specify in sufficient detail the actual jumper to be lifted to prevent the 4B emergency diesel generator from starting during the test.

III. EVENT SAFETY ANALYSIS

The 4B emergency diesel generator operated as designed during the integrated safeguards test procedure. The automatic start would not have prevented the 4B emergency diesel generator from performing its intended function had a loss of offsite power occurred concurrently. Therefore, the health and safety of plant personnel or the general public were not compromised by the automatic start of the 4B emergency diesel generator.

IV. CORRECTIVE ACTIONS

1. Administrative procedure 0-ADM-501, Duties and Responsibilities of System Engineers, will be revised to require the field verification of the adequacy of work operations. This revision is scheduled to be completed by January 31, 1993.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME	DOCKET NUMBER	LER NUMBER	PAGE NO.
TURKEY POINT UNIT 4	05000251	92-010-00	03 OF 03

2. Administrative Procedure 0-ADM-101, Procedure Writers Guide, will be revised to require the originator of procedure steps requiring lifting of leads or installation of jumpers to field verify the adequacy of terminal and or wire identification steps in the procedure steps added. This procedure change is scheduled to be complete by January 31, 1993.
3. An internal memo was issued to all department heads. The memo directed managers to inform personnel of their responsibility when writing a procedure step, which requires the lift of a wire or installation of a jumper, to provide detail sufficient to result in a unique description of the work location.

V. ADDITIONAL INFORMATION

No other unexpected actuations of engineered safety features from opposite train testing have occurred in the past two years.

