

ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8807050086 DOC. DATE: 88/06/27 NOTARIZED: NO DOCKET #
 FACIL: 50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
 AUTH. NAME AUTHOR AFFILIATION
 HART, R.D. Florida Power & Light Co.
 CONWAY, W.F. Florida Power & Light Co.
 RECIPIENT NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-010-00: on 880528, containment ventilation & control room ventilation isolation occurred.

W/8 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4
 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

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	AEOD/DSP/ROAB	2 2	AEOD/DSP/TPAB	1 1
	ARM/DCTS/DAB	1 1	DEDRO	1 1
	NRR/DEST/ADS 7E	1 0	NRR/DEST/CEB 8H	1 1
	NRR/DEST/ESB 8D	1 1	NRR/DEST/ICSB 7	1 1
	NRR/DEST/MEB 9H	1 1	NRR/DEST/MTB 9H	1 1
	NRR/DEST/PSB 8D	1 1	NRR/DEST/RSB 8E	1 1
	NRR/DEST/SGB 8D	1 1	NRR/DLPQ/HFB 10	1 1
	NRR/DLPQ/QAB 10	1 1	NRR/DOEA/EAB 11	1 1
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	NRR/DRIS/SIB 9A	1 1	NUDOCS-ABSTRACT	1 1
	REG/REG 02	1 1	RES TELFORD, J	1 1
	RES/DE/EIB	1 1	RES/DRPS DEPY	1 1
	RGN2 FILE 01	1 1		
EXTERNAL:	EG&G WILLIAMS, S	4 4	FORD BLDG HOY, A	1 1
	H ST LOBBY WARD	1 1	LPDR	1 1
	NRC PDR	1 1	NSIC HARRIS, J	1 1
	NSIC MAYS, G	1 1		

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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) **Containment Ventilation and Control Room Ventilation Isolation While Containment Particulate Radiation Monitor Setpoint Was Being Checked on Two Separate Occasions**

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 5	2 8	8 8	8 8	0 1 0	0 0	0 6	2 7	8 8	Turkey Point Unit 4		0 5 0 0 0 2 5 1
											0 5 0 0 0

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
POWER LEVEL (10) 1 0 0	20.402(b)		20.406(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)		73.71(b)			
	20.406(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)			
	20.406(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
	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)(x)					

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
NAME Randall D. Hart, Licensing Engineer		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	
X	I L A	N N	T 2 6 0	Y							

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 May 28, 1988, with Unit 3 and Unit 4 in mode 1 (power operation) the Containment Radioactive Particulate Monitor (R-11) setpoint was being verified. The usual method of verifying the setpoint is by pressing the High Alarm pushbutton, then reading the setpoint from the instrument's digital display. As the High Alarm pushbutton was being pressed, an alarm signal was generated. This resulted in actuation of the Control Room Ventilation and Containment Ventilation Systems isolation circuitry. The systems that were not already in their actuated position actuated as required. R-11 was taken out of service and the problem investigated. After troubleshooting could not find any problems, Operations requested that R-11 be placed back in service to assist in monitoring containment activity during problems with the number 1 seal leakoff on the 3A reactor coolant pump. R-11 was tested in accordance with the normal surveillance procedure on May 30, 1988. During this test, Containment and Control Room Ventilation Isolation signals were generated when the high alarm pushbutton was depressed. Again the systems that were not already in their actuated position actuated as designed. The drawer for R-11 was replaced. The drawer has been returned to the manufacturer for root cause analysis. Upon completion of the drawer replacement, R-11 was satisfactorily tested and placed back in service.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

EVENT:

On May 28, 1988, with Unit 3 at 100% power and Unit 4 at approximately 48% power the Containment Radioactive Particulate Monitor (R-11) (EIIS:IL) setpoint was being verified. The method used to verify the setpoint was pressing the High Alarm pushbutton, then reading the setpoint from the instrument's digital display. At 1345, as the High Alarm pushbutton was being pressed, an unexpected alarm signal was generated. This resulted in actuation of the Control Room Ventilation and Containment Ventilation Systems (EIIS:JM) isolation circuitry. At the time of generation of the signal the containment purge valves were closed and the control room ventilation system was out of service under a 45 day action statement per Technical Specification 3.4.7. On receipt of the signal, these systems did not actuate since they were in their design configuration. However, the instrument air bleed valves were open and they did close upon receipt of the originating signal as required.

R-11 was declared out of service and maintenance was requested to investigate the problem. The Instrument and Control Department (I&C) reopened plant work order (PWO) 7994 that had been worked on May 27, 1988 due to a filter failure light problem. The previous problem had been identified to be a loose wing nut on the filter paper take up reel. On May 29, 1988, troubleshooting was begun in accordance with general maintenance procedure O-GMI-102.1, Troubleshooting and Repair Guidelines. The journeyman performed sections 6.3, 6.4, and 6.5 of preventive maintenance procedure O-PMI-067.1, Process Radiation Monitoring System Channel R-3-11 and R-3-12 Calibration Procedure, to check the calibration of the channel circuitry. No problems were found during the calibration check. At this time, Operations requested that R-11 be placed back in service to assist in monitoring containment activity because of problems experienced with the 3A reactor coolant pump number 1 seal leakoff flow. Operations began to place R-11 back in service by performing operating surveillance procedure (OSP) 3-OSP-067.1, Process Radiation Monitoring Operability Test, on May 30, 1988. During this test, Containment and Control Room Ventilation signals were again generated when the high alarm pushbutton was depressed. Again the systems actuated as designed. R-11 was maintained out of service and I&C requested to continue troubleshooting.

CAUSE OF EVENT:

The drawer for R-11 was replaced. The suspect drawer has been sent back to the manufacturer for repair and root cause analysis.

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 (6)			PAGE (3)	
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		8 8	- 0 1 0	- 0 0	0 3	OF 0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

ANALYSIS OF EVENT:

Upon actuation of the R-11 High Alarm trip circuit, the Containment and Control Room Ventilation Systems that were not already in their actuated position isolated per design. During this event process radiation detector R-12 (containment air gaseous detector) was operable and did not indicate any significant increases in containment activity. Both R-11 and R-12 on Unit 4 were operable during this event. The signal generated on Unit 3 did not affect any equipment on Unit 4. No radiation releases were detected during this event. Based on the above, the health and safety of the public were not affected.

CORRECTIVE ACTIONS:

- 1) After the actuation on May 28, 1988, the drawer was checked and no abnormal conditions were found.
- 2) The drawer for R-11 was replaced. The suspect drawer has been sent back to the manufacturer for repair and calibration. The vendor had been requested to provide a root cause analysis report for the failure.
- 3) After completion of the drawer replacement, R-11 was satisfactorily tested and placed back in service.

ADDITIONAL INFORMATION:

Similar occurrences: LERs 250-87-032, 251-86-030, 250-87-005, 250-87-008, 251-87-021, 251-87-023, 251-88-002, and 250-87-30 were previous R-11 or R-12 actuations.

LER 250-88-003 reported a similar actuation of R-11 when the high alarm pushbutton was depressed. That LER was not able to pinpoint a root cause for the R-11 actuation.

Manufacturer: Nuclear Research Corp. Model Number: DRM-200.

The digital rate meter was model number DRM-200V6 and serial number RM781803.



JUNE 27 1988

L-88-271
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 3 and 4
Docket No. 50-250 and 50-251
Reportable Event: 250-88-10
Date of Event: May 28, 1988
Containment Ventilation and Control Room
Ventilation Isolation While Containment
Particulate Radiation Monitor Setpoint
Was Being Checked on Two Separate Occasions

The attached Licensee Event Report (LER) is being submitted pursuant to the requirements of 10 CFR 50.73 to provide notification of the subject event.

Very truly yours,

W. F. Conway
W. F. Conway
Senior Vice President - Nuclear

WFC/SDF/gp

Attachment

cc: Dr. J. Nelson Grace, Regional Administrator,
Region II, USNRC
Senior Resident Inspector, USNRC, Turkey Point Plant

SDF3.LER

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