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FACIL:50-250 Turkey Point Plant, Unit 3, Florida Power and Light C 05000250
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PLUNKETT,T.F. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-004-00:on 910822,inadvertently start of 3A diesel generator occurred.Touching together of lifted leads, providing rapid start signal.Training of Startup personnel on revs to SFP-2 & SFP-21.W/910919 ltr.

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P.O. Box 029100, Miami, FL, 33102-9100

SEP 19 1991

L-91-258
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 No. 50-250
Reportable Event: 91-004-00
Date of Event: August 22, 1991
Inadvertent Start of 3A Emergency Diesel Generator

The attached Licensee Event Report 250-91-004-00 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/clm

Attachment

cc: Stewart D. Ebneter, Regional Administrator, Region II, USNRC

Senior Resident Inspector, USNRC, Turkey Point Plant

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
TURKEY POINT UNIT 3	05000250	1 OF 3

TITLE (4) INADVERTENT START OF 3A 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 # (S)
08	22	91	91	004	00	09	19	91		

OPERATING MODE (9)	N	10 CFR 50.73(A)(2)(iv)
POWER LEVEL (10)	000	

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 ☐	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
(if yes, complete EXPECTED SUBMISSION DATE)				

ABSTRACT (16)

At 1955 on August 22, 1991, the 3A Emergency Diesel Generator (EDG) inadvertently started. Startup personnel were performing a scheme verification on wire leads located in a newly replaced cable in the 3A EDG rapid start circuit. When they lifted the rapid start leads the EDG started, due to shorting the leads together. The leads were relanded, and the EDG was shut down. The cause of the event was inadequate communication between Startup personnel and licensed operators. The Nuclear Watch Engineer and the Assistant Plant Supervisor - Nuclear knew the work involved the 3A EDG but were unaware that leads would be lifted. The Unit 3 Reactor Control Operator knew that leads would be lifted, but thought the work was on the 3B EDG. Startup Field Procedures have been revised to require that the Plant Supervisor - Nuclear give concurrence, by signature, to perform any scheme verifications on an energized circuit. Startup personnel have been trained on the procedure revisions. Operators will be briefed on this event, and the implications of ineffective communications.

I. EVENT DESCRIPTION

At 1955 on August 22, 1991, the 3A Emergency Diesel Generator (EDG) (EIIS:EB, Component:DG), was inadvertently started. A cable from the EDG to the Control Room, for the rapid start circuit had been replaced, and Startup personnel (contractor personnel) were to perform a scheme verification.

The Startup personnel discussed their work with the Nuclear Watch Engineer and the Assistant Plant Supervisor - Nuclear (both licensed senior operators). Both operators understood that the scheme verification was to be performed on the 3A EDG, but were under the impression that only a visual examination would be done.

The test was also discussed with the Unit 3 Reactor Control Operator (licensed reactor operator). He understood that leads would be lifted, but thought the work was being done on the 3B EDG. The 3A EDG had been returned to normal standby alignment, and the 3B EDG removed from service, earlier that evening.

The Startup personnel performing the scheme verification knew their work was on the 3A EDG, and that it involved lifting leads, but did not expect that lifting the lead would cause a rapid start of the EDG.

When the leads for the rapid start circuit were lifted, the 3A EDG underwent a rapid start. The leads were inadvertently shorted together, simulating the depressing of the rapid start push button, which completed the signal path and caused the EDG rapid start.

The 3A EDG was shut down at 2015, and the NRCOC was notified of the significant event at 2023.

II. EVENT CAUSE

The immediate cause of the 3A EDG autostart was the touching together of lifted leads, providing a rapid start signal.

The root cause of the event was inadequate communication between the licensed operators and the test technicians. Had the proper precautions been taken, such as notification of the PS-N in conjunction with an isolation (clearance or startup blue tag) on the proper control circuits, this event would not have occurred.

III. EVENT SAFETY ANALYSIS

Unit 3 was shut down and defueled, approaching the end of an extended dual unit outage. The EDGs were not required to be operable, in accordance with the safety evaluation governing plant operations during the dual unit outage. The scheme verification being performed on the 3A EDG was in preparation for a test of the rapid start circuit, so the operability or functionality of the EDG was not affected by the rapid start. Since the EDG was not required to be operable, the inadvertent start did not affect the health or safety of the public.

IV. CORRECTIVE ACTIONS

1. Procedures SFP-2, Startup Test Control General Guidelines, and SFP-21, Scheme Verification, were revised to require PS-N notification and concurrence prior to testing equipment which affects, or may affect, operating systems.

2. In addition, an existing precaution that circuits to be tested must be isolated from operating systems, "as necessary," was revised. SFP-21 now requires the PS-N's signature on the scheme verification test data record if the circuit to be tested is not isolated, or if isolation is indeterminate.

3. Training of Startup personnel on the revisions to SFP-2 and SFP-21 has begun, and will be completed by September 23, 1991.

4. Although shorting the leads together is considered an isolated incident, it is indicative of careless work habits. The contractor test technician has been counseled on his carelessness. His supervisor, also a contractor, is no longer on site.

5. This event and its causes will be discussed with all licensed operators as an example of the need for effective communications. The discussions will be completed by October 15, 1991.

V. ADDITIONAL INFORMATION

Licensee Event Report 250-91-002 described a similar inadvertent actuation, attributed to inadequate work controls.