

# ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

## REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9110080350      DOC. DATE: 91/09/30      NOTARIZED: NO      DOCKET #  
 FACIL: 50-250 Turkey Point Plant, Unit 3, Florida Power and Light C      05000250  
 AUTH. NAME      AUTHOR AFFILIATION  
 POWELL, D.R.      Florida Power & Light Co.  
 PLUNKETT, T.F.      Florida Power & Light Co.  
 RECIP. NAME      RECIPIENT AFFILIATION

SUBJECT: LER 91-005-00: on 910830, 3A Component Cooling Water (CCW)  
 Pump started automatically on low pressure due to personnel  
 error. Training brief will be written & distributed to  
 appropriate personnel to discuss subj LER.W/910930 ltr.

DISTRIBUTION CODE: IE22T      COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4  
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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EXTERNAL:	EG&G BRYCE, J.H		3	3		L ST LOBBY WARD		1	1
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P.O. Box 029100, Miami, FL, 33102-9100

SEP 30 1991

L-91-249  
10 CFR 50.73

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

Gentlemen:

Re: Turkey Point Unit 3  
Docket No. 50-250  
Reportable Event: 91-005-00  
Date of Event: August 30, 1991  
Automatic Start of 3A Component Cooling Water (CCW) Pump  
on Low CCW Pressure Due to Personnel Error

The attached Licensee Event Report 250-91-005-00 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/DPS/ds

enclosures

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

9110080350 910930  
PDR ADOCK 05000250  
S PDR

# LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <p style="text-align: center;">TURKEY POINT UNIT 3</p>	DOCKET NUMBER (2) <p style="text-align: center;">05000250</p>	PAGE (3) <p style="text-align: center;">1 OF 3</p>
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TITLE (4) **AUTOMATIC START OF 3A COMPONENT COOLING WATER (CCW) PUMP ON LOW PRESSURE DUE TO PERSONNEL ERROR**

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)
08	30	91	91	005	00	09	30	91			

OPERATING MODE (9)	6	<u>10 CFR 50.73(a)(2)(iv)</u>
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	NFRDS?	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	NFRDS?

SUPPLEMENTAL REPORT EXPECTED (14) . NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
(if yes, complete EXPECTED SUBMISSION DATE)				

ABSTRACT (16)

At 1250 EDT, on August 30, 1991, with Unit 3 in Mode 6 (Refueling) and Unit 4 defueled, the 3A Component Cooling Water (CCW) Pump started automatically on a low CCW system pressure signal. After removing the temporary spent fuel pool cooling connections, the CCW piping to and from the spent fuel pool heat exchanger was refilled with CCW water to restore normal spent fuel pool cooling. While refilling these lines, the CCW surge tank level decreased to five percent. At five percent surge tank level, the control room operator stopped the 3A and 3B CCW Pumps to prevent cavitation. The 3A CCW pump restarted automatically. The 3A CCW pump was immediately secured. Both 3A and 3B CCW pumps were placed in "pull to lock" to prevent another automatic start. After restoring the surge tank level, CCW pump 3A was restarted. A four hour non-emergency report was made to the NRC at 1417 EDT in accordance with 10 CFR 50.72. The root cause of this event was non-cognitive personnel error by plant licensed operators. An inadequate briefing coupled with less than adequate coordination between the personnel involved resulted in a failure to anticipate reduced water inventory. The immediate cause was the failure to place the CCW pumps in "pull-to-lock" when the pumps were secured to prevent cavitation. To prevent recurrence, a series of meetings briefings were held with applicable operations personnel to discuss proper briefings for fill and vent operations.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME DOCKET NUMBER LER NUMBER PAGE NO.  
TURKEY POINT UNIT 3 05000250 91-005-00 02 OF 03

I. EVENT DESCRIPTION

At 1250 EDT, on August 30, 1991, with Unit 3 in Mode 6 (Refueling) and Unit 4 defueled, after removing the temporary spent fuel pool cooling connections, the Component Cooling Water (CCW) piping (CC)(PSP) to and from the spent fuel pool heat exchanger (CC)(HX) was refilled with CCW water to restore normal spent fuel pool cooling. While refilling these lines, the CCW surge tank level decreased to five percent. At five percent surge tank level, the control room operator stopped the 3A and 3B CCW Pumps (CC)(P) to prevent cavitation. The 3A CCW Pump restarted automatically on a low CCW system pressure. The 3A CCW pump was immediately secured to prevent cavitation. Both 3A and 3B CCW pumps were placed in "pull to lock" to prevent another automatic start. After restoring the surge tank level, CCW pump 3A was restarted. Although this automatic start was not due to an engineered safety feature (ESF) signal, Florida Power and Light conservatively reported this automatic start as an ESF actuation. A four hour non-emergency report was made to the NRC at 1417 EDT in accordance with 10 CFR 50.72.

II. EVENT CAUSE

The root cause of this event was non-cognitive personnel error by plant licensed operators. The errors include those listed below:

1. Immediate Cause

The immediate cause of the automatic start was the failure to place the CCW pumps in "pull-to-lock" when the pumps were secured to prevent cavitation. The only corrective action for low surge tank level listed in procedure 3-ONOP-030, "Component Cooling Water Malfunction," that was applicable for this event was to increase make up to the surge water tank. Procedure 3-ONOP-030 requires that the CCW pumps be stopped and placed in "pull-to-lock," if they are cavitating. The operator did not enter this portion of the procedure prior to the pump autostart because both CCW pumps were stopped as a preventive measure before they cavitated.

2. Root Cause

An inadequate briefing coupled with less than adequate coordination between the personnel involved resulted in a failure to anticipate the reduced water inventory. The instructions for releasing the clearance did not provide sufficient guidance to prevent low level in the surge tank upon removal of the clearance.

III. EVENT SAFETY ANALYSIS

Other than the automatic initiation of CCW pump 3A, there were no other manual or automatic reactor protection system or engineered safety features actuations. No other manual or automatic actions were required or expected. The automatic start of the 3A CCW pump was in accordance with the design of the CCW system for the conditions that existed at that time (low CCW system pressure). Based on the above, the health and safety of the public were not adversely affected.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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FACILITY NAME                      DOCKET NUMBER                      LER NUMBER                      PAGE NO.  
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IV. CORRECTIVE ACTIONS

1. A series of meetings were held with applicable operations personnel to discuss proper briefings for fill and vent operations. This event and related items were placed in the night orders to ensure the on-shift crews were familiar with the event and the requirements for a proper briefing for fill and vent operations.
2. A post event review of this event was performed with the responsible operators.
3. Shift Supervisors are being counseled on the need to emphasize coordination and communication between personnel for all events. This event will be included in that counseling. This will be completed by October 14, 1991.
4. A training brief will be written and distributed to appropriate personnel for their review. This training brief will discuss this Licensee Event Report (LER) and the three LERs listed in the Additional Information section below. This action will be completed by October 31, 1991.

V. ADDITIONAL INFORMATION

LER 250-90-007 describes an automatic start of the 3B CCW pump due to low discharge header pressure after securing one of the pump supply lines as part of a surveillance procedure. This event was caused by an inadequate surveillance procedure.

LER 251-90-006 describes an automatic start of the 4B CCW pump due to low discharge pressure when one of the two operating pumps was secured without reducing the number of components being supplied by CCW. This event was caused by a failure to follow the surveillance procedure which called for the isolation of CCW from the RHR heat exchanger prior to securing the CCW pump.

LER 251-90-007 describes an automatic start of the 4A CCW pump due to low discharge pressure during transient conditions while swapping CCW heat exchangers. This event was caused by a cognitive personnel error when the calibration data sheet was not updated to reflect the new low discharge pressure setpoint.



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