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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 92-013-00:on 921116,during preparations for emergency diesel generator load rejection test lockout of 3A 4 Kv safeguards bus occurred due to incorrect installation of stationary contact.T bar removed.W/921209 ltr.

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L-92-333
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: 92-013-00
3A Safeguards Bus De-energized During Testing

The attached Licensee Event Report 250-92-013-00 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. Ebneter, Regional Administrator, Region II, USNRC
Ross C. Butcher, 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 3	05000250	1 OF 3

TITLE (4) 3A Safeguards Bus De-energized During Testing

EVENT DATE (5)				LER NUMBER (6)			RPT DATE (7)				OTHER FACILITIES INV. (8)	
MON	DAY	YR		YR	SEQ #	R#	MON	DAY	YR		NAME	DOCKET # (5)
11	16	92		92	013	00	12	09	92			

OPERATING MODE (2)	5	10 CFR 50.73(a)(2)(iv)
POWER LEVEL (10)	0	

LICENSEE CONTACT FOR THIS LER (12)

	TELEPHONE NUMBER
James E. Knorr, Regulation and Compliance Specialist	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)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES	(If yes, complete EXPECTED SUBMISSION DATE)	NO X				

ABSTRACT (16)

During preparations for an emergency diesel generator load rejection test, a lockout of the 3A 4 Kv safeguards bus occurred. While closing breaker 3AA22 while in the test position, a lockout relay mounted on the back panel of the breaker cabinet was actuated due to vibration. The vibration was caused by a "T" bar installed on the breaker for the purpose of actuating stationary contacts. The root cause was identified to be the installation of the "T" bar in a configuration which caused contact with the stationary contact housing. This housing contact caused vibration of the back panel of the cabinet, resulting in a bus lockout relay actuation.

As corrective action, the "T" bar was removed and the emergency diesel generator load rejection testing was completed.

I. DESCRIPTION OF THE EVENT

During the early stages of the train "A" engineered safeguards test, an unexpected lockout of the 3A bus (EIIS-EB) (IEEE-BU) occurred. As part of the safeguards test sequence, the 3A emergency diesel generator (EDG) (EIIS-EK) (IEEE-DG) is run for a 24 hour load test prior to a load rejection test. At 0752 EST on November 16, 1992, approximately 23 hours into the load test, Turkey Point personnel racked breaker 3AA22 (EIIS-EB) (IEEE-BKR) into the test position without incident. Breaker 3AA22 is the Unit 3 "A" train 4 Kv emergency bus cross tie to the Unit 4 startup transformer (EIIS-EB) (IEEE-XFMR) . During the next step of closing 3AA22, as required by the surveillance procedure 3-OSP-203.1, Train A Engineered Safeguards Integrated Test, an unexpected bus lockout occurred on Train "A" with a load shed and trip of the supply breakers from both the Unit 3 startup transformer and the 3A EDG. The 3A bus was de-energized as a result of the lockout.

There was no effect on the Train "B" 3B 4 Kv bus or its connected loads. The residual heat removal system (EIIS-BP) and other cooling water system (EIIS-BS) loads were maintained on Train "B" prior to the beginning of the Train "A" testing. There were also no effects on the Unit 4 electrical systems.

II. CAUSE OF THE EVENT

The root cause of the bus lockout has been determined to be the incorrect installation of the stationary contact actuation "T" bar. As part of the preparations for the integrated safeguards test, breaker 3AA22 was placed in the test position. To actuate various stationary contacts while the breaker is in the test position, a "T" bar extension was installed on the breaker. The "T" bar is an extension of the normal (racked-in position) mechanism which actuates stationary contacts. Depending on the vertical adjustment made on the "T" bar during installation the bar can make physical contact with the stationary contact housing itself during the closing process. This contact housing contact caused vibration in the breaker cabinet back panel.

The 3AA22 breaker has bus lockout relay 174TDDO installed on the back panel of the cabinet interior. As required by procedure 3-OSP-203.1, the "T" bar was installed to allow the verification of the operation of auxiliary relay stationary contacts normally only operated when the breaker was in its normal racked-in position. The "T" bar is normally installed with some small amount of clearance between the "T" bar and the stationary contacts. However, in this case the bar was installed with minimal clearance such that when the 3AA22 breaker was closed while in its test position the "T" bar movement resulted in some contact with the stationary contact housing causing vibration of the back panel in the cabinet and thereby an intermittent closure of the 174TDDO bus lockout relay.

During the trouble shooting process Turkey Point personnel verified that the lockout relay operation was caused by the "tight" installation of the "T" bar. The lockout did not occur with the "T" bar removed or with the "T" bar installed with a normal amount of clearance.

III. ANALYSIS OF THE EVENT

The "T" bar is only installed during the conduct of the type of testing requiring the verification of the actuation of stationary contacts. In this event, during the procedurally controlled testing process, the loads on the bus being tested are not energized and therefore, the loss of power to the bus had no effect on the safety of the plant. Decay heat removal systems and all auxiliary systems powered by the 3B 4 Kv bus were not affected. Therefore the health and safety of plant personnel and the general public were not affected by the loss of power to the 3A 4 Kv bus.

IV. CORRECTIVE ACTIONS

1. To assure no untoward actions with the breaker in the racked in position, the gap between the breaker and the stationary contacts plunger was checked with the breaker in the racked in position.

2. A walkdown was conducted by plant personnel which verified that the 3AA22 breaker was the only cubicle that had a 174TDDO relay providing a bus lockout on the back cubicle panel. Relays are normally installed on the side panels of the cubicle.

3. The Operations Surveillance Procedure which controls the system configuration setup for the integrated safeguards test will be revised to provide a caution concerning the installation of a "T" bar. This procedure revision will be completed prior to the next use of the procedure.

4. A cautionary sign has been installed on cubicle 3AA22 to warn of the sensitivity of relay 174TDDO to mechanical vibration during the use of a "T" bar.

5. An engineering evaluation will be conducted to evaluate the efficacy of enhancing the existing 174TDDO relay installation or possible replacement of the relay with a type less sensitive to vibration. Changes based upon this evaluation, as appropriate, will be scheduled as part of the Turkey Point plant change/modification prioritization process.

V. ADDITIONAL INFORMATION

None.