

LICENSEE EVENT REPORT (LER)

| | | |
|---|--|------------------------|
| FACILITY NAME (1) Turkey Point Plant - Unit 4 | DOCKET NUMBER (2) 0 5 0 0 0 0 2 5 1 | PAGE (3) 1 OF 0 2 |
|---|--|------------------------|

TITLE (4)
Loss of Containment Integrity

| 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 | 9 | 8 | 4 | 8 | 4 | - | 0 | 0 | 9 | - | 0 | 0 | 0 | 6 | 2 | 8 | 8 | 4 | N/A | 0 5 0 0 0 |
| N/A | | | | | | | | | | | | | | | | | | | | | | |

OPERATING MODE (9) **N**

POWER LEVEL (10) **0 | 0 | 0**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

| | | | |
|-------------------|--|----------------------|--|
| 20.402(b) | 20.406(c) | 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) | <input checked="" type="checkbox"/> 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)(ix) | |

LICENSEE CONTACT FOR THIS LER (12)

| | |
|--|---|
| NAME | TELEPHONE NUMBER |
| Jesus Arias, Jr., Regulation and Compliance Lead Engineer | 3 0 5 2 4 5 - 2 9 1 0 |

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 |
|-------|-----------|-----------|---------------|---------------------|-------|--------|-----------|--------------|---------------------|
| B | J M F | Q V | I 2 0 7 | Y | | | | | |

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

| | | | |
|-------------------------------|-------|-----|------|
| EXPECTED SUBMISSION DATE (15) | MONTH | DAY | YEAR |
| | | | |

ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single space typewritten lines) (16)

On May 27, 1984, while Unit 4 was at hot shutdown, an attempt was made to drain the Reactor Coolant Drain Tank (RCDT). Low flow was observed from the discharge of the RCDT pumps. Following investigations, it was determined that the low flow was caused by blockage in FCV-4-4668A (Phase A containment isolation valve). Maintenance found and replaced a damaged diaphragm. On May 28, 1984, with the Unit 4 still at hot shutdown, low flow was again observed while attempting to drain the RCDT. A damaged diaphragm in FCV-4-4668A was again discovered and replaced. Adjustments to the valve stroke were made.

On May 29, 1984, a review of the sequence of events and respective clearances issued to perform repairs revealed that, even though there was no direct flow path from containment to the outside environment, containment integrity was technically breached. The flow path from the RCDT to outside environment was isolated by means of valves not qualified as containment isolation valves. This is contrary to T.S. 1.25 - Definitions of Containment Integrity and thus, it is reportable under 10 CFR 50.73. An Unusual Event was declared on May 29, 1984, and the State of Florida and NRCOC were properly notified of the May 27, 1984 occurrence. There was no potential for radioactive releases to the atmosphere, thus, the health and safety of the public were not affected.

On May 30, 1984, FCV-4-4668A failed once more. While investigating the root cause of repeat failures, it was discovered that damaged O-rings in the stem guide to the valve actuator were causing the diaphragm failures. Proper notifications under 10 CFR 50.72 and Emergency Plan were made to State and NRCOC.

Similar occurrences: None. Corrective actions are included in the text portion of this report.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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|---|--|----------------|----------------------------|------------------------|----------|--------|
| FACILITY NAME (1) Turkey Point Plant - Unit 4 | DOCKET NUMBER (2) 0 5 0 0 0 2 5 1 | LER NUMBER (6) | | | PAGE (3) | |
| | | YEAR 8 4 | SEQUENTIAL NUMBER 0 0 9 | REVISION NUMBER 0 0 | 0 2 | OF 0 2 |

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

On May 27, 1984, while Unit 4 was at hot shutdown, an attempt was made to drain the Reactor Coolant Drain Tank (RCDT). Low flow was observed from the discharge of the RCDT pumps. Following investigations, it was determined that the low flow condition was caused by blockage in FCV-4-4668A (Phase A containment isolation valve). Maintenance personnel found and replaced a damaged diaphragm. On May 28, 1984, with Unit 4 still at hot shutdown, low flow was again observed while attempting to drain the RCDT. A damaged diaphragm was again discovered in FCV-4-4668A and replaced. In addition, adjustments to the valve stroke were made.

On May 29, 1984, (first working day following a holiday weekend), plant management performed an in-depth review of the occurrence, sequence of events, and respective clearances issued to perform repairs to FCV-4-4668A. As a result, it was discovered that containment integrity was technically breached while performing repairs, even though there was no physical direct path from containment to the outside environment. At 6:07 p.m., an Unusual Event was declared and proper notifications made. On May 30, 1984, Unit 4 was still at hot shutdown when FCV-4-4668A failed again while attempting to drain the RCDT. Further in-depth investigations were performed to determine root cause for repeat failures in FCV-4-4668A. It was discovered that damaged O-rings in the stem guide to the actuator were causing the diaphragm failures. The damaged O-rings were replaced and FCV-4-4668A was returned to service following successful leak rate testing. Proper notifications of declaration of an Unusual Event were made to the State and NRCOC.

As a result of in-depth reviews of the incident, the following corrective actions have been or will be taken to preclude recurrence:

1. A letter of instruction to all reactor operators, department heads, and supervisors has been issued clarifying the technical definitions of containment boundary valves.
2. Training Department will review the Unusual Event classification of the Emergency Plan in future requal sessions. It is our intention to further familiarize each operator (RO/SRO) with unusual events.
3. A statement will be added to the Equipment Out of Service log to increase each operator's awareness of valves affecting containment integrity.
4. Development of a procedure listing all containment boundary valves and the conditions required prior to exceeding 200°F in a unit's reactor coolant system.

Neither of the previous described occurrences had any effect on the health and safety of the public.



June 28, 1984
PNS-LI-84-222

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

Gentlemen:

Re: Reportable Event 84-009
Turkey Point Unit 4
Date of Event: May 29, 1984
Loss of Containment Integrity

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

Very truly yours,

A handwritten signature in cursive script, appearing to read "J. W. Williams, Jr.", is written over the typed name.

J. W. Williams, Jr.
Group Vice President
Nuclear Energy

JWW/SAV/js

Attachment

cc: J. P. O'Reilly, Region II, USNRC
Harold F. Reis, Esquire
File 933.1 TP

JE22
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