NRC Form 366 (14.43) LICENSEE EVENT REPORT (LER)									U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3169-6164 EXPIRES: 8/31/88								
FACILITY NAME (1)								DOCKET NUMBER				GE (3)					
Turkey Point Unit 4										0 5 0 0	1012	5 1	1 OF	0 12			
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EVENT DATE (5) LER NUMBER (6)				REPORT DATE (7) OTHE				FACILITIES INVOLVED (8)									
MONTH	DAY	YEAR	YE	AR	SEQUENTIAL REVI		REVEION	MONTH	DAY	YEAR		FACILITY NA	MES	DOCKET	NUMBER	(5)	-
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MODE (9)				20.4021	b)		20.406(a) X 50.73(a)(2)(iv)						73	.71(b)			
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								50.38(e)(2) 50.73(e)(2)(viii)						OTHER (Specify in Abstract			
				20.4081	a)(1)(iii)			50.73(a	1(2)(i)			50,73(a)(2)(viii)((A)		6A)	Test, NA	C Form
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G. Salamon, Compliance Engineer											AREA CODE						
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SUPPLEMENTAL REPORT EXPECTED (14)									-	MONTH	DAY	YEAR					
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Event:

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On September 8, 1986, at 1020, with Unit 4 at 29% power, Phase A Containment Isolation (CI) of train B was actuated. At the time of the actuation, operations personnel were checking the status of the train B lights in safeguards rack 44. At the conclusion of the light check, in order to facilitate closing the safeguards rack door, a wire bundle was moved. While it was being moved, it inadvertently came in contact with relay SIA2. The jarring, due to the inadvertent contact, actuated train B Phase A CI. Upon actuation, the valves required to close did close, or were either already closed or de-energized per plant status. determining that containment conditions did not warrant Phase A isolation, train B of Phase A CI was reset.

Cause of event:

The cause of the Phase A CI was personnel error and wire bundle/relay interference. location and length of the wire bundle, along with the location of relay SIA2, requires more than the usual amount of caution to be exercised upon closing of the door. The inadvertent contact of the wire bundle with relay SIA2 resulted from not recognizing the need for extra care when the door was being closed.

Corrective action:

- 1) Upon confirming that containment conditions did not warrant Phase A CI, the Phase A CI actuation signal was reset, and the valves which had closed were reopened.
- 2) A Request for Technical Assistance was written in order to resolve the wire bundle/relay interference using engineering direction.
- 3) The technicians on the job were rebriefed on the proper precautions to be taken to prevent inadvertent actuation of the relays.

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NRC Form 386A (9-43)	LICENSEE EVE	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION								U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPRES: 8/31/88						
PACILITY NAME (1)		DOCKET NUMBER (2)		L	ER NUMBER (0		PAGE (3)								
			YEAR		SEQUENTIAL		MEVISION NUMBER				-					
Turkey Point	Unit 4	0 5 0 0 0 2 5 1	8 6	_	0 2 2	_	010	012	OF	0 12	2					

Event:

On September 8, 1986, at 1020, with Unit 4 at 29% power, Phase A Containment Isolation (CI) of train B was actuated. At the time of the actuation, operations personnel were checking the status of the train B lights in safeguards rack 44. At the conclusion of the light check, in order to facilitate closing the safeguards rack door, a wire bundle was moved. While it was being moved, it inadvertently came in contact with relay SIA2. The jarring, due to the inadvertent contact, actuated train B Phase A CI. Upon actuation, the valves required to close did close, or were either already closed or de-energized per plant status. After determining that containment conditions did not warrant Phase A isolation, train B of Phase A CI was reset.

Cause of event:

The cause of the Phase A CI was personnel error and wire bundle/relay interference. The location and length of the wire bundle, along with the location of relay SIA2, requires more than the usual amount of caution to be exercised upon closing of the door. The inadvertent contact of the wire bundle with relay SIA2 resulted from not recognizing the need for extra care when the door was being closed.

Analysis of event:

At the time of the Phase A CI's the unit was at 29% power. The Phase A CI actuation signals were generated by the making up of relay SIA2. Certain valves were already closed prior to the CI actuation, and others were de-energized, per plant status. The remaining valves closed, as designed. Based on the above, the health and safety of the public were not affected.

Corrective action:

1) Upon confirming that containment conditions did not warrant Phase A CI, the Phase A CI actuation signal was reset, and the valves which had closed were reopened.

2) A Request for Technical Assistance was written in order to resolve the wire bundle/relay

interference using engineering direction.

 The technicians on the job were rebriefed on the proper precautions to be taken to prevent inadvertent actuation of the relays.

Additional Details: Similar Occurrences: LER 251-86-004, 251-86-005, 251-86-013.



OCTOBER 08 1986 L-86-414

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

Gentlemen:

Re: Reportable Event 86-22

Turkey Point Unit 4

Date of Event: September 8, 1986

Inadvertent Relay Actuation During Inspection Causes Phase A Containment Isolation Actuation

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

Very truly yours,

C. O. Woody
Group Vice President
Nuclear Energy

CGW/RG/qp

Attachment

cc: Dr. J. Nelson Grace, Region II, USNRC Harold F. Reis, Esquire

IE22