NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0|1] F L T P S 3 (2) LICENSEE CODE | 0 0 - 0 0 0 0 0 - 0 0 (3) LICENSE NUMBER | 4 1 1 1 1 (4) LICENSE TYPE | (5) CAT

CON'T [0|1] REPORT SOURCE L (6) | 0 5 0 0 0 2 5 0 (7) DOCKET NUMBER | 0 3 0 9 8 3 (8) EVENT DATE | 0 3 2 3 8 3 (9) REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[0|2] On 3/9/83, rod control clusters D8 and M8 of control bank D simultaneously
[0|3] dropped while Unit 3 was operating at 100% power. As per T.S.3.2.4.a, sustained
[0|4] power operation of the unit shall not be permitted with more than one inoper-
[0|5] able control rod. This is reportable under T.S.6.9.a.2. This is the first
[0|6] occurrence of this type. Approximately 15 minutes after the automatic turbine
[0|7] runback and manual power reduction to hot shutdown was initiated, the 2
[0|8] dropped rods were retrieved. A flux map verified proper position of the rods.

[0|9]

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
R B (11)	E (12)	X (13)	C O N R O D (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 3	—	0 0 5	/	0 1	T	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	G (19)	B (20)	A (21)	0 0 0 0	Y (23)	N (24)	N (25)	W 1 2 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[1|0] The cause was a momentary short in the lead to the stationary coils due to
[1|1] water that was getting inside the control rod power cabinet. The water leak-
[1|2] age was stopped the cabinet was dried, and the unit was returned to full
[1|3] power. Westinghouse was consulted and it was determined that no safety
[1|4] limits were encroached upon during this incident.

[1|5] FACILITY STATUS E (28) | % POWER 1 0 0 (29) | OTHER STATUS (30) NA | METHOD OF DISCOVERY A (31) | DISCOVERY DESCRIPTION (32) Operator observation

[1|6] ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) NA | LOCATION OF RELEASE (36) NA

PERSONNEL EXPOSURES

[1|7] NUMBER 0 0 0 (37) | TYPE Z (38) | DESCRIPTION (39) NA

PERSONNEL INJURIES

[1|8] NUMBER 0 0 0 (40) | DESCRIPTION (41) NA

LOSS OF OR DAMAGE TO FACILITY (43)

[1|9] TYPE Z (42) | DESCRIPTION NA

PUBLICITY

[2|0] ISSUED N (44) | DESCRIPTION (45) NA | NRC USE ONLY

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S PDR

Additional Cause Description and Corrective Actions

NIS and RPI dropped rod circuitry caused an automatic turbine runback to 70% power. According to plant procedures, power reduction to hot shutdown was initiated. Within approximately fifteen minutes after the shutdown began, the two dropped rods were retrieved and were verified to be back in the correct position by a flux map. Immediate inspection of the control rod power cabinet revealed that water was dripping onto the cabinet and seeping inside. It appears that the water inside the cabinet resulted in a momentary short in the lead to the D-8 and M-8 control rod stationary coils. The cabinet was dried and the water leakage was stopped at the source. The unit was returned to full power. Westinghouse was consulted and it was determined that no safety limits were encroached upon, due to the short duration of the incident and the subsequent operability of the two control rods.

The simultaneous dropping of two control rods is a rare event. Turkey Point's plant procedures mainly address operator action in the case of one dropped rod. The occurrence on March 9, 1983 has made plant personnel aware of the need to address the multiple-dropped-rod incident in the operating procedures. Westinghouse will be consulted for guidance in writing the new immediate actions for the multiple-dropped-rod incident.