

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Turkey Point Unit 3										DOCKET NUMBER (2) 0 5 0 0 0 2 5 0										PAGE (3) 1 OF 0 1														
TITLE (4) Engineered Safety Features (ESF) Actuation - Train "B" Equipment																																		
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)									
																				N/A					0 5 0 0 0 . . .									
0 6			1 7		8 5		8 5		0 1		7		0 0			0 7		1 7		8 5		N/A					0 5 0 0 0 . . .							
OPERATING MODE (9) 6					THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																													
POWER LEVEL (10) 0 0 0					20.402(b)					20.406(e)					X					80.73(a)(2)(iv)					73.71(b)									
					20.406(a)(1)(i)					80.36(e)(1)										80.73(a)(2)(v)					73.71(e)									
					20.406(a)(1)(ii)					80.36(e)(2)										80.73(a)(2)(vi)					OTHER (Specify in Abstract below and in Text, NRC Form 366A)									
					20.406(a)(1)(iii)					80.73(a)(2)(i)										80.73(a)(2)(viii)(A)														
					20.406(a)(1)(iv)					80.73(a)(2)(ii)										80.73(a)(2)(viii)(B)														
					20.406(a)(1)(v)					80.73(a)(2)(iii)										80.73(a)(2)(ix)														
LICENSBEE CONTACT FOR THIS LER (12)																																		
NAME R. L. Teuteberg, Regulation and Compliance Engineer															TELEPHONE NUMBER AREA CODE 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 NRC				CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NRC														
SUPPLEMENTAL REPORT EXPECTED (14)															EXPECTED SUBMISSION DATE (15)					MONTH					DAY					YEAR				
YES (If yes, complete EXPECTED SUBMISSION DATE)										X NO																								
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)																																		

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

Event: On June 17, 1985, while Unit 3 was in a scheduled refueling outage and Unit 4 was at hot standby conditions for Unit 3 safeguards testing, a spurious safety injection signal was generated in the Unit 3 Engineered Safety Features system which actuated Train "B" safeguards equipment. At the time of the event, operating personnel were searching for a ground on one of two Unit 3 125 volt DC busses by opening and reclosing breakers using an off-normal operating procedure. Upon opening and reclosing breaker 3D23-9, a spurious safety injection signal was generated which initiated the start of Unit 3 Train "B" safeguards equipment, including the 3 B and 4 B safety injection pumps. Although the Train "B" safety injection pumps started, no resultant safety injection flow was delivered to the Unit 3 reactor coolant system (RCS) because the RCS inlet valves were procedurally closed for refueling activities. Following the safety injection actuation, the proper operation of safeguards equipment was verified using an emergency operating procedure. All equipment actuated by the Engineered Safety Features Actuation signals functioned as designed.

Cause of Event: The cause of the safeguards activation was the inadvertent use of the wrong page from the appendix of a procedure being used to identify the source of a ground on the 3D23 DC bus. While using the page applicable to bus 3D01, the operator was opening and closing the corresponding breakers powered from the redundant DC bus 3D23.

Corrective Actions:The following corrective actions were taken after the event:

- 1) Using an emergency procedure, safeguards equipment were verified to have actuated properly upon initiation of the safety injection signal.
- 2) Safeguards equipment which had actuated were returned to their normal operating status when the cause of the safeguards initiation was verified.
- 3) The operator involved in the event was counseled on the exercise of greater care in using plant procedures.

The health and safety of the public were not affected. Similar Occurrences: LER 250-84-003, 250-84-014, 250-84-029, 251-84-008, 250-85-003 and 250-85-004.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)
		YEAR	REVISION NUMBER
Turkey Point Unit 3	0 5 0 0 0 2 5 0	8 5 - 0 1 7 - 0 0 0 2	OF 0 2

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

Event:

On June 17, 1985, at 7:00 p.m., while Unit 3 was in a scheduled refueling outage and Unit 4 was at hot standby conditions for Unit 3 safeguards testing, a spurious safety injection signal was generated in the Engineered Safety Features system which actuated Train "B" safeguards equipment. The Unit 3 Train "B" safety injection pumps were actuated with no resultant safety injection flow delivered to the Unit 3 reactor coolant system. At the time of the event, operating personnel were searching for a ground on one of two Unit 3 125 volt DC system busses, the 3D23 bus, which had annunciated in the control room. Off Normal Operating Procedure (ONOP) 9608.1, "125 V DC System -Location of Grounds," was being used to locate and isolate the source of a ground. Appendix A of ONOP 9608.1 identifies those breakers that are powered from each of the 125 volt DC busses and identifies which breakers can be cycled open and closed to locate the source of a ground. While opening and reclosing breakers on the 3D23 bus, the operator inadvertently used the ONOP 9608.1 Appendix A instruction sheet for the corresponding breakers on the other DC system bus 3D01.

When the operator opened the 3D23-9 breaker which powers the Sequencer Panel 3C23B and Safeguards Rack No. 45, this unblocked the safety injection logic. Upon reclosing breaker 3D23-9, a spurious safety injection signal was generated which initiated the start of the Unit 3 Train "B" safety injection pumps, the 3B emergency containment cooler and filter, and other Train "B" engineered safeguards equipment. Although the 3B and 4B high-head safety injection pumps started, no flow was delivered to the Unit 3 reactor coolant system (RCS), because the RCS motor operated inlet valves were closed and their breakers were racked-out on a proceduralized clearance for the refueling shutdown. Following the safety injection initiation, the proper operation of safeguards equipment was verified using an emergency operating procedure. All equipment actuated by the Engineered Safety Features Actuation signals functioned as designed. The safety injection actuation system was subsequently reset, since the inadvertent cause of the safeguards actuation was identified as described below.

Cause of Event:

The cause of the safeguards actuation was the inadvertent use of the wrong page from the appendix of a procedure being used to identify the source of a ground on the 3D23 DC bus. While using the page applicable to bus 3D01, the operator was opening and closing the corresponding breakers powered from the redundant DC bus 3D23.

Analysis of Event:

During the event, Unit 3 was in a scheduled refueling outage. Engineered safeguards equipment were verified to have functioned as designed upon actuation of the safety injection signals. The cause of the event was identified as having resulted from the inadvertent actions described above. Based on the above, the health and safety of the public were not affected.

Corrective Actions:

The following corrective actions were taken after the event:

- 1) Using an emergency procedure, safeguards equipment were verified to have actuated properly upon initiation of the safety injection signal.
- 2) Safeguards equipment which had actuated were returned to their normal operating status when the cause of the safeguards initiation was verified.
- 3) The operator involved in the event was counseled on the exercise of greater care in using plant procedures.



JUL 17 1985

L-85-276

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

Gentlemen:

Re: Reportable Event 85-17
Turkey Point Unit #3
Date of Event: June 17, 1985
Engineered Safety Features (ESF) Actuation - Train "C" Equipment

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 dark ink, appearing to read "J. W. Williams, Jr.", is written over a horizontal line.

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

JWW/PLP/tla

Attachment

cc: Dr. J. Nelson Grace, Region II, USNRC
Harold F. Reis, Esquire
File 933.1
PNS-LI-85-264

IE 22

PEOPLE . . . SERVING PEOPLE

11