

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-II-04-012

This preliminary notification constitutes EARLY notice of events of possible safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region II staff (Atlanta, Georgia) on this date.

Facility

Turkey Point Nuclear Plant
Unit 3
Homestead, FL
Dockets/License: 50-250/DPR-31

Licensee Emergency Classification

	Notification of Unusual Event
	Alert
	Site Area Emergency
	General Emergency
X	Not Applicable

Subject: FIRE IN TURBINE BEARING AREA RESULTS IN SHUTDOWN GREATER THAN TWO DAYS

On December 14, 2004 at approximately at 11:40 am, Turkey Point Unit 3 experienced a fire at the number 2 bearing of the high pressure turbine. The onsite fire brigade responded and extinguished the fire by 11:49 am. The unit was manually tripped at 11:45 am. No personnel injury was reported and offsite fire brigade assistance was not required.

All control rods fully inserted and all safety equipment responded as designed. Following the manual reactor trip, the 3B S/G feedwater pump (FWP) experienced bearing high temperatures and the pump was secured. The licensee observed that the 3B FWP minimum flow valve did not open as expected following the reactor trip. Initial information indicates that this resulted in operating the pump without a discharge flow path and may have caused the bearing high temperature condition and possible FWP bearing damage.

The licensee initiated an Event Response Team (ERT) to investigate and determine the cause of the fire and the extent of the damage. Preliminary investigation results indicate that the source of the fire was lubricating oil soaked insulation. There was no fire damage to plant equipment. The oil leak at the number 2 bearing was apparently caused by an oil seal installation issue that occurred 18 months ago. The licensee is investigating the cause of the 3B S/G feedwater pump bearing high temperature condition.

An NRC inspector onsite responded to the event, monitored the licensee's implementation of reactor trip recovery actions and is closely monitoring the licensee's investigations and corrective actions. Region II received initial notification of this occurrence by telephone from the NRC inspector at the site. This information presented herein has been discussed with the licensee and is current as of December 16, 2004.

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