NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

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

TITLE (4)

Engineered Safety Feature Actuation - Reactor Trip

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 1	0 8	8 4	8 4	0 0 1	0 0	0 2	0 7	8 4	N/A	0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
N		20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 3 0		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Paul A. Roach, Regulation and Compliance 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	

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)

On January 8, 1984, a reactor trip occurred. The root cause was determined to be due to a spurious signal which resulted in closure of the 'A' steam generator (S/G) feedwater flow control valve. The transient resulted in "Steam Flow/Feedwater Flow Mismatch" coincident with "Low 'A' S/G Water Level" protection signals which tripped the reactor. All equipment functioned as designed on initiation of the Engineered Safety Feature Actuation Signal (ESFAS). Plant personnel checked the flow control valve and associated components and satisfactorily stroked the valve open and closed. No abnormalities were determined to exist that could have caused the valve to close. The flow control valve and associated components have functioned without problem since. The health and safety of the public were not affected. Similar occurrences: LER 250-80-24.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Turkey Point Unit 3	0 5 0 0 0 2 5 0	8 4	— 0 0 1	— 0 0	0 2 OF 0 2

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

On January 8, 1984, at 2:05 a.m., the Unit 3 reactor tripped from approximately 30 percent power while performing the unit evolution - hot shutdown to power operation. The root cause was determined to be due to a spurious signal which resulted in closure of the 'A' steam generator (S/G) feedwater flow control valve (FCV-3-478). The valves associated Hagan hand-auto station was controlling in the manual mode when a spurious signal occurred resulting in closure of FCV-3-478. The transient resulted in a reactor trip on Reactor Protection System (RPS) logic - "Steam Flow/Feedwater Flow Mismatch" (1/2 channels) coincident with "Low 'A' S/G Water Level" (1/3 S/Gs).

Verifying S/G chemistry to be within specifications prior to exceeding 30 percent power is performed under step 8.52 of Operating Procedure 0202.2, Unit Start-up -Hot Shutdown to Power Operation. While holding for S/G chemistry at 30 percent power, plant personnel were troubleshooting fluctuations observed in positioning of FCV-3-478 experienced with the associated Hagan hand-auto station controlling in the auto mode. The manual mode was selected while troubleshooting the 'auto' control fluctuations in accordance with normal operating practice. Operations personnel were cognizant of the situation and maintained 'manual' control of the 'A' S/G water level until a spurious signal occurred and resulted in closure of FCV-3-478. Attempts to re-open FCV-3-478 were successful but not able to prevent the trip due the slower response of the valve when being controlled in the manual mode. Plant personnel checked FCV-3-478 and satisfactorily stroked the valve open and closed from the control room in the manual mode. A circuit check of the Hagan hand-auto station (specifically, circuits associated with the manual mode of control) revealed no abnormalities that could have caused FCV-3-478 to close. Since the fluctuations observed when controlling FCV-3-478 in the auto mode were not associated with the trip, the details of actions taken to correct these fluctuations will be reported to the Nuclear Plant Reliability Data System. The Hagan hand-auto station and FCV-3-478 have functioned without problem since.

All equipment functioned as designed on initiation of the Engineered Safety Feature Actuation Signal generated in the RPS. Following completion of the post-trip review, having identified no other problems, the unit evolution hot shutdown to power operation re-commenced.

FLORIDA POWER & LIGHT COMPANY

February 7, 1984
PNS-LI-84-45

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

Gentlemen:

Re: Reportable Event 83-01
Turkey Point Unit 3
Date of Event: January 8, 1984
Engineered Safety Feature Activation

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,

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

JWW/PLP:djc

Attachment

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

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