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On July 16, 1984, while at cold shutdown conditions, Unit 4 experienced an unexpected start of the 4A high head safety injection (HHSI) pump. The root cause was determined to stem from construction personnel inadvertently striking the local control switch on the 4A breaker cubicle. Construction personnel were installing scaffolding in the vicinity of the breaker and due to the limited space between the scaffolding and switchgear, they brushed against the local switch starting the pump. No Engineered Safety Feature Actuation Signal (ESFAS) was present, therefore, the valves did not line up and no flow was delivered to the core. Immediate corrective actions included: 1) the 4A HHSI pump was stopped and in an attempt to verify the root cause, plant personnel recreated the events at the breaker cubicle which indeed started the pump, and 2) construction personnel were cautioned about the importance of being careful when working in the vicinity of electrical breakers. The health and safety of the public were not affected. Similar occurrences: LER 250-84-007, LER 250-84-012, and LER 251-84-006.

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

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August 10 1984 PNS-LI-84-284

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

Gentlemen:

Re:

Reportable Event 84-15

Turkey Point Unit 4 50 -251 Date of Event: July 16, 1984

Engineered Safety Feature Actuation-Safety Injection Pump Actuation

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,

Group Vice President Nuclear Energy

JWW/PLP/js

Attachment

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

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PEOPLE ... SERVING PEOPLE