

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 2

TITLE (4): Technical Specification - Safety Injection Pump

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)
02	28	86	86	007	000	03	14	86	N/A	0 5 0 0 0
									N/A	0 5 0 0 0

OPERATING MODE (9): 3
POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11):

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.38(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.38(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12):

NAME: Randall D. Hart, Licensing Engineer
TELEPHONE NUMBER: 3 0 5 2 4 5 - 2 9 1 0
AREA CODE: 3 0 5

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): YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15): MONTH: DAY: YEAR:

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

Event: On February 17, 1986, while Unit 3 was at 100% power, it was discovered that the 4B high head safety injection (HHSI) pump had been out-of-service (OOS) during a Unit 3 start-up on February 12, 1986. At 0018 on February 17, 1986, the 4B HHSI pump was started to fill the 3C accumulator. There was no indication of pressure or flow to the accumulator so the pump was shut down. An investigation into the problem revealed that pump discharge valve 888D and the header tie valve 845D to Unit 3 were closed on clearance 4-86-2-033, on February 5, 1986 and remained closed to isolate MOV-4-369 for repacking. On the morning of February 12 during a walkdown for the start-up of Unit 3, permission was given to temporarily lift the clearance on the pump breaker but clearance release for the valves was not obtained. The 4B HHSI pump was satisfactorily tested for start-up but the high head injection path for the 4B HHSI pump remained isolated and therefore not in compliance with the requirements of Technical Specification 3.4.1.a.4.

Cause of Event: An investigation into the cause of the event has revealed that an oversight in the review of Unit 4 clearances allowed the 4B HHSI to be declared in service with its discharge valves closed.

Corrective Actions:

- 1) The need to follow through on tasks, and the importance of thorough shift turnovers was re-emphasized to operating personnel.
- 2) The clearance procedure will be enhanced to maintain clearances for shared equipment in a separate book to ease the review prior to restart.
- 3) Procedures will be changed to list clearances in the equipment OOS book.
- 4) This event will be reviewed and discussed with licensed personnel during the next operator requalification training schedule.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

TEXT (If more space is required, use additional NRC Form 368A's) (17)

Event:

On February 17, 1986, while Unit 3 was at 100% power, it was discovered that the 4B high head safety injection (HHSI) pump had been out-of-service (OOS) during a Unit 3 start-up on February 12, 1986. At 0018 on February 17, 1986, the 4B HHSI pump was started to fill the 3C accumulator. There was no indication of pressure or flow to the accumulator so the pump was shut down. An investigation into the problem revealed that pump discharge valve 888D and the header tie valve 845D to Unit 3 were closed. These valves were closed on February 5, 1986 and remained closed to isolate MOV-4-869 for repacking. On the morning of February 12 during a walkdown for the start-up of Unit 3, a clearance tag, 4-86-2-033, was found on the 4B HHSI pump breaker. A temporary lift was done on breaker 4AB12 on clearance 4-86-2-033 to allow for testing of the 4B HHSI pump. However, the rest of the clearance was not released. The 4B HHSI pump was satisfactorily tested in accordance with Operating Procedure (OP) 4104.1, High Head Safety Injection System - Periodic Test for start-up. Since valves 888D and 845D remained closed, the high head injection path for the 4B pump was OOS and not in compliance with Technical Specification 3.4.1.a.4 during the start-up of Unit 3 on February 12, 1986.

Cause of Event:

An investigation into the cause of the event has revealed that an oversight in the review of Unit 4 clearances allowed the 4B HHSI to be declared in service with its discharge valves closed.

Analysis of Event:

During this event, the 3A, 3B, and 4A SI pumps were operable. Unit 4 was in a scheduled refueling outage with the core off-loaded. So in this configuration, the three operable SI pumps were available for use on Unit 3 if the need had arisen. Based on the above, the health and safety of the public were not affected.

Corrective Actions:

- 1) The clearance on the 4B HHSI pump including valves 888D and 845D was lifted on February 17, 1986 and the pump satisfactorily tested.
- 2) The need to follow through on tasks, and the importance of thorough shift turnovers was re-emphasized to operating personnel.
- 3) The clearance procedure will be enhanced to maintain clearances for shared equipment in a separate book to ease the review prior to restart.
- 4) Procedures will be changed to list clearances in the equipment OOS book.
- 5) This event will be reviewed and discussed with licensed personnel during the next operator requalification training schedule.

Additional Details:

Similar occurrences: LER 250-85-034.



March 14, 1986
L-86-117

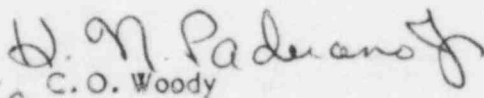
U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Gentlemen:

Re: **REPORTABLE EVENT 86-7**
TURKEY POINT UNIT 3
DATE OF EVENT: FEBRUARY 12, 1986
TECHNICAL SPECIFICATION
SAFETY INJECTION PUMP

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,

for 
C. O. Woody
Group Vice President
Nuclear Energy

COW/SAV:dee

Attachment

cc: Dr. J. Nelson Grace, Region II, US NRC
Harold F. Reis, Esquire
File 933.1
PNS-LI-86-84

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