

LICENSEE EVENT REPORT

CONTROL BLOCK: _____ (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | F | L | T | P | S | 3 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

LICENSEE CODE LICENSE NUMBER LICENSE TYPE JO CAT 58

CONT

0 1 | R | E | P | O | R | T | S | O | U | R | C | E | L | 6 | 0 | 5 | 0 | 0 | 0 | 2 | 5 | 0 | 7 | 1 | 1 | 0 | 4 | 8 | 2 | 3 | 1 | 2 | 0 | 3 | 8 | 2 | 9

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | During a normal operational evolution, the 3A high head safety injection

0 3 | pump would not start from manual operation of either the Unit 3 or Unit 4

0 4 | control switch. The other three HHSI pumps were available and Unit 4 was

0 5 | shutdown and defueled at the time. The health and safety of the public was

0 6 | not affected. This is reportable in accordance with Technical Specification

0 7 | 6.9.2.b.2. A similar event was reported as LER 250-82-008.

0 8 | _____

0 9 | S | F | 11 | E | 12 | X | 13 | P | U | M | P | X | X | 14 | B | 15 | Z | 16

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE

17 | LER/RO REPORT NUMBER | 8 | 2 | 21 | 22 | 0 | 1 | 5 | 24 | 26 | 0 | 3 | 28 | 29 | L | 30 | 31 | 0 | 32

18 | ACTION TAKEN | X | 18 | 33 | Z | 19 | 34 | Z | 20 | 35 | Z | 21 | 36 | 0 | 0 | 0 | 0 | 37 | Y | 23 | 40 | Y | 24 | 41 | N | 25 | 42 | W | 1 | 2 | 0 | 25 | 44 | 47

EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRO-4 FORM SUB. PRIME COMP SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The 3A HHSI pump breaker was racked out and back in. The pump was then succ-

1 1 | essfully started. The breaker and control circuitry were thoroughly checked,

1 2 | but a specific failure mode could not be identified. After two repairs were

1 3 | made to the breaker, a special test was performed which cycled breaker 3AA13

1 4 | fifty times. A failure did not occur, and the pump was returned to service.

1 5 | E | 28 | 1 | 0 | 0 | 29 | NA | 30 | A | 31 | Operational Event | 32

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

FACILITY STATUS % POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)

1 6 | Z | 33 | Z | 34 | NA | 35 | N/A | 36

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

1 7 | 0 | 0 | 0 | 37 | Z | 38 | NA | 39

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)

1 8 | 0 | 0 | 0 | 40 | NA | 41

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

PERSONNEL INJURIES NUMBER DESCRIPTION (41)

1 9 | Z | 42 | NA | 43

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION (43)

2 0 | N | 44 | NA | 45

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33

ISSUED DESCRIPTION (45) PDR ADOCK 05000250 S PDR

NAME OF PREPARER Z. E. Berry PHONE: (305) 245-2910, Ext. 353

Additional Cause Description and Corrective Actions

During a normal operational evolution, an attempt was made to start the 3A high head safety injection pump by manually operating the Unit 3 control switch. The pump would not start. Another attempt was made to start the pump using the 3A HHSI pump switch on Unit 4. This was also unsuccessful. Operations personnel made a visual inspection of breaker 3AA13. No problems were apparent. The breaker was racked out and back in. The pump then started successfully from the Unit 3 control switch.

The following day, an inspection of the pump's breaker and circuitry by the Electrical Department discovered nothing that could be positively identified as the cause of the failure. Two repairs were made. An adjustment was made to the breaker elevator permissive switch because the control arm had been binding. A screw on one of the fuse blocks was found loose and was tightened. A test to verify operability following the maintenance work was successful.

Because this event was similar to one that had occurred on June 9, 1982, a special test was performed in an attempt to recreate the event and determine the location of the failure in the 3A HHSI pump breaker or circuitry. The leads to the 3A HHSI pump motor were disconnected and the Unit 3 control switch was cycled fifty times while electrical department personnel verified that the breaker closed upon each switch operation. The entire test of fifty switch operations proceeded without failure. The leads to the motor were reconnected and an operability test of the pump was successfully completed.

Since the root cause of the problem could not be determined by the initial inspection and cycling the breaker fifty times after the repairs did not demonstrate a failure like the occurrences of June 9, 1982 and November 4, 1982, the pump was returned to service with reasonable assurance that a recurrence of this type of failure is a highly improbable event.

Component Data

The 3A HHSI pump is a horizontal centrifugal pump manufactured by Worthington. The pump's motor was made by Westinghouse and the breaker is manufactured by General Electric.