

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK:

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7	8	9						14						15	25						26	30					57	58	
		LICENSEE CODE						LICENSE NUMBER														LICENSE TYPE							

CON'T

0	1
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REPORT SOURCE

L	6	0	5	0	0	0	3	0	9	7	0	4	0	5	8	3	8	0	4	2	5	8	3	9
60	61								68	69						74	75							80
DOCKET NUMBER										EVENT DATE								REPORT DATE						

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | SEE ATTACHED

03 _____

0	4	
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08 _____ 8

SYSTEM CODE S F (11)		CAUSE CODE A (12)		CAUSE SUBCODE A (13)		COMPONENT CODE C K T B R K (14)				COMP. SUBCODE E (15)		VALVE SUBCODE 2 (16)	
LER/RO REPORT NUMBER 17		EVENT YEAR 8 3 (21 22)		SEQUENTIAL REPORT NO. 0 0 9 (24 25 26)		OCCURRENCE CODE 0 3 (28 29)		REPORT TYPE L (30)		REVISION NO. 0 (32)			
ACTION TAKEN X (18)		FUTURE ACTION G (19)		EFFECT ON PLANT Z (20)		SHUTDOWN METHOD Z (21)		HOURS 0 0 0 0 (22 23 24 25)		ATTACHMENT SUBMITTED N (23)		NPRD-4 FORM SUB. N (24)	
PRIME COMP. SUPPLIER A (25)		COMPONENT MANUFACTURER G 0 8 0 (26 27 28 29)											

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | SEE ATTACHED

1	1	
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1 2 |

1	3	
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14

7 8 9 FACILITY STATUS 1 5 28 E 29 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 OTHER STATUS 30 METHOD OF DISCOVERY 31 B 32 DISCOVERY DESCRIPTION 33 ECCS Monthly Surveillance 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)

1 6 Z 33 Z 34 NA

LOCATION OF RELEASE (36)

NA

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0	0	0	(37)	Z	(38)	NA	(39)

PERSONNEL INJURIES	
NUMBER	DESCRIPTION
1 8 0 0 0	(40) NA

1	9	Z	42	NA	8305060549 830425 PDR ADCK 05000309 S PDR
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7 8 9 10
PUBLICITY
ISSUED (2) (0) N (44) DESCRIPTION (45) NA
NRC USE ONLY

PHONE: 207 - 882-6321

LER #83-009/03L-0

EVENT DESCRIPTION AND PROBABLE OCCURRENCE (10)

On April 5, 1983, with the plant at full power, the P-14S (spare) HPSI pump would not start during monthly ECCS surveillance. P-14S was in "A" train alignment while P-14A was out of service for corrective maintenance. The P-14B HPSI pump was operating in charging service.

Failure of the P-14S pump to start resulted in a degraded mode condition as per Technical Specification 3.6.B. The "B" train emergency diesel generator was tested within two hours, which met the remedial action requirements.

Investigation revealed that a ground truck that had been racked up in the P-14A pump breaker cubicle on March 7, 1983, activated a housing limit switch interlock, which prevented the start of P-14S. Raising the breaker elevator, which can carry either a breaker or a ground truck, causes the switch to change state. This unusual type of interlock is unique to Maine Yankee safeguards pumps that can be functionally replaced by installed spare pumps. The use of spare pumps allows preventative and corrective maintenance to be performed without the loss of ECCS redundancy. The interlock is intended to prevent auto start operation of two HPSI train pumps from the same bus when the spare pump is being used.

The ground truck was racked down and P-14S tested satisfactorily within five hours of deficiency discovery.

A similar event occurred in 1972 during pre-commercial testing operations. The single corrective measure taken at that time (in retrospect obviously inadequate) was to stencil a warning sign on the affected circuit breaker doors.

During the entire period from the time the ground truck was racked up until discovery of the problem, P-14B was operating in charging service, capable of automatically providing HPSI flow. However, on March 17, 1983, the "B" train emergency diesel generator was removed from service for 6 hours, 45 minutes for preventative maintenance. This would have resulted in neither HPSI train being automatically operable during the period if an SIAS had been present coincident with a loss of offsite power.

There was no impact on the health and safety of the public.

LER #83-009/03L-0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

The causes of the incident included lack of operational procedural guidance, failure of personnel to understand and comply with a sign stenciled on the breaker cubicle door, and the unique pump start interlock design which could be actuated in circumstances other than intended.

No specific procedural precautions, controls or training existed to prevent elevator motion, and the resultant limit switch block of P-14S start. The sign stenciled on the breaker cubicle door warned against leaving a ground truck racked up in the cubicle, but was not explicit as to the reason. The interlock should have been designed to activate only when racking up a breaker, not simply when the elevator was raised.

1. As soon as the error was discovered, the ground truck was racked down, tagged and locked, and P-14S was tested satisfactorily.
2. The breaker elevator was tagged to prevent further inadvertent manipulation during the repair of P-14A.
3. Strict procedural and administrative controls have been established for all safeguards pumps where this design feature exists to prevent reoccurrence of the problem.
4. An Operations Department Memorandum warning of the problem and describing the new procedural controls has been issued. Plant operators were required to review the memorandum and document their review in writing.
5. A new more explicit warning sign will be placed in all affected safeguards pump cubicles to prevent inadvertent elevator motion with a spare pump in service.
6. The ground truck use procedure has been revised to include a precaution relative to the interlock on the affected breakers.
7. The function of the interlocks will be added to operator and electrical maintenance training programs.
8. A precaution statement regarding the interlock will be added to the S pump procedures. The procedures will also be strengthened to preclude other misalignment possibilities.
9. A design change providing for the interlock only during breaker operations is being evaluated.