

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) D. C. Cook Nuclear Plant - Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 3 1 6 1 0 0 3															
TITLE (4) ESF (Safety Injection) Pump Returned to Service Following Maintenance by Non QA-Qualified Vendor Due to Personnel Error																									
EVENT DATE (8)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (5)															
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES					DOCKET NUMBER(S)											
1	1	1	2	8	6	8	6	0	3	1	0	0	1	2	1	2	8	6	0	5	0	0	0	1	1
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 2. (Check one or more of the following) (11)																							
1		20.402(d)				20.406(d)				99.736(d)(2)(iv)				73.71(d)											
POWER LEVEL (10)		20.406(d)(1)(i)				99.736(d)(1)				99.736(d)(2)(iv)				73.71(a)											
0		20.406(d)(1)(ii)				99.736(d)(2)				99.736(d)(2)(iv)				OTHER (Specify in Abstract below and in Text, NRC Form 365A)											
		20.406(d)(1)(iii)				X 99.736(d)(2)(i)				99.736(d)(2)(iv)(A)															
		20.406(d)(1)(iv)				99.736(d)(2)(ii)				99.736(d)(2)(iv)(B)															
		20.406(d)(1)(v)				99.736(d)(2)(iii)				99.736(d)(2)(iv)(C)															
LICENSEE CONTACT FOR THIS LER (12)																									
NAME J. D. Allard - Maintenance Superintendent										TELEPHONE NUMBER															
										AREA CODE 6 1 6 4 6 5 - 5 9 0 1															
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)										EXPECTED SUBMISSION DATE (15)					MONTH	DAY	YEAR								
X YES (If yes, complete EXPECTED SUBMISSION DATE)															0	2	2	7	8	7					
NO																									
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																									

On 11/12/86, it was discovered, during a review of environmental qualifications, that the North Safety Injection Pump motor had been serviced by a non QA-qualified vendor in May of 1981. The pump was removed from service, due to our inability to conclusively prove the impact of the servicing on the motors environmental qualifications.

The cause of the event has been determined to be due to personnel error in that the vendor was not QA qualified. We believe that the servicing performed on this motor did not degrade it's ability to function during an accident, had one occurred. To verify our belief the motor will undergo environmental qualification tests. A supplemental report containing the test program will be submitted by 2/27/87.

On 11/13/86 the motor in question was removed and replaced with a certified motor. Since the occurrence of the subject event (1981) administrative controls have been strengthened, which ensures the use of qualified vendors when necessary. Based on the effectiveness of these controls, no additional preventive action is currently planned.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (2)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		86	031	00	02	OF	03

TEXT (if more space is required, use additional NRC Form 306A's) (17)

Conditions Prior to Occurrence

Unit Two - 90 percent reactor thermal power.

Description of Event

On November 12, 1986, it was discovered, during a review of environmental qualifications, that the Unit Two North Safety Injection (EIIS/BQ) Pump motor (EIIS/MO) had been serviced by a non QA-qualified vendor in May of 1981. Subsequently the pump was removed from service, (declared inoperable at 1500 on 11/12/86) due to our inability to conclusively prove the impact of the servicing on the motors environmental qualifications.

The Unit Two North Safety Injection Pump motor had been sent to the vendor in May of 1981 to have the motor dynamically balanced. However, the vendor also performed steam cleaning of the motor and a varnish treatment of the stator coils. This work was beyond the scope of the requested repairs.

The pump motor was returned to the plant and installed in May, 1981. The pump motor had been in service (without problems) until November 12, 1986.

There were no other inoperable structures, components or systems that contributed to this event.

Cause of Event

The cause of this event has been determined to be due to personnel error in that involved Maint./Purchasing personnel did not consider the QA-qualification of the vendor. In a non QA-facility there is no assurance that any repairs done would be performed to original motor requirements.

Analysis of Event

We have concluded that the use of this motor was in violation of Technical Specification 3.5.5 and consequently, is reportable per 10CFR50.73(a) (2) (i) (B).

During the period of May, 1981 to November, 1986 the motor was periodically run per Technical Specification Surveillance requirements.

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D. C. Cook Nuclear Plant - Unit 2	0 5 0 0 0 3 1 6	8 6	— 0 3 1	— 0 0	0 3	OF	0 3

TEXT (If more space is required, use additional NRC Form 315A-1 (17))

We believe that the servicing performed on this motor, by a non QA-qualified vendor, did not degrade it's ability to function during an accident, had one occurred. In order to verify our belief it has been decided to perform the required environmental qualification tests for the motor. A supplemental report containing the test program and its schedule will be submitted by February 27, 1987.

Corrective Actions

On November 13, 1986 the Unit Two North Safety Injection Pump motor was removed and replaced with a certified motor. The motor removed will be subjected to the required environmental qualification tests to verify that the motor's ability to function under accident conditions was not degraded.

Since the occurrence of the subject event (1981) administrative controls have been strengthened, which ensures the use of qualified vendors when necessary. Based on the effectiveness of these controls, no additional preventive action is currently planned.

Failed Component Identification

None

Previous Similar Events

None identified at this time.