

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

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REPORT
SOURCE

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60	61	DOCKET NUMBER										68	EVENT DATE					74	REPORT DATE							80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 While in cold shutdown conditions, emergency feedwater pump EF-P-2 failed to start
0 3 during a surveillance test. The degraded condition was considered to have existed
0 4 since an oil change on October 2, 1983, which spanned a period of time during hot shut-
0 5 down greater than the time allowed by Technical Specifications. This was considered
0 6 to be in violation of T.S. 3.4.2 and reportable under T. S. 6.9.2.A.2. while shutdown,
0 7 decay heat was at a minimum, however if the plant had been operating, other sources of
0 8 decay heat removal would have been available. Public health and safety were unaffected

SYSTEM CODE H H 11		CAUSE CODE E 12		CAUSE SUBCODE A 13		COMPONENT CODE C K T B R K 14		COMP. SUBCODE X 15		VALVE SUBCODE Z 16	
LER/RO REPORT NUMBER 8 3 17		EVENT YEAR 8 3 21 22		SEQUENTIAL REPORT NO. 0 4 3 24 26		OCCURRENCE CODE 0 1 28 29		REPORT TYPE T 30		REVISION NO. 0 32	
ACTION TAKEN A 18		FUTURE ACTION G 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22		ATTACHMENT SUBMITTED Y 23	
NPRD-4 FORM SUB. Y 24		PRIME COMP. SUPPLIER A 25		COMPONENT MANUFACTURER W 1 2 1 26							

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The root cause was determined to be a broken fuse clip. A contributing factor to this

1 1 event was failure to adequately perform post maintenance testing. The fuse holder was

1 2 replaced and the pump tested satisfactorily. The preventive maintenance procedure for

1 3 oil change will be revised to clearly reflect post-maintenance testing requirements.

1 4

8 9
FACILITY STATUS (28) % POWER (0 0 0) (29) OTHER STATUS (30) N/A METHOD OF DISCOVERY (B) (31) DISCOVERY DESCRIPTION (32) Operator Observation
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 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) LOCATION OF RELEASE (36) N/A
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39) N/A
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
PERSONNEL INJURIES NUMBER DESCRIPTION (41) N/A
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION (43) N/A
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
PUBLICITY ISSUED DESCRIPTION (45) N/A
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
2 0 (46) N/A
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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
8312130327 831123
PDR ADOCK 05000289
S PDR
NRC USE ONLY
68 69

NAME OF PREPARER M. R. Knight

BUONE (717) 948-8647

EMERGENCY FEEDWATER PUMP EF-P-2A INOPERABLE

EVENT DATE - NOVEMBER 6, 1983

I. CURRENT ACTIVITIES AT THE TIME OF OCCURRENCE

TMI Unit 1 was in a cold shutdown condition with the RCS partially drained to perform maintenance on RCS valves.

II. CIRCUMSTANCES LEADING TO THE OCCURRENCE

Surveillance Procedure 1300-3F A/B (Motor Driven Emergency Feedwater Functional Test) was being performed.

III. DESCRIPTION

During the performance of the test, Emergency Feedwater Pump EF-P2A failed to start from the control switch on console left in the Control Room.

An investigation revealed that EF-1-2 had been taken out of service for an oil change on October 2, 1983 at 0030 and restored to standby operation at 0150 the same day without post maintenance testing. The RCS was at hot shutdown conditions at that time. Since EF-P-2A had not been taken out of service since the oil change prior to the November 6, 1983 surveillance testing, the pump was considered to have been inoperable while the unit was in hot shutdown.

This condition was considered to be in violation of T.S. 3.4.2 and reportable under T.S. 6.9.2.A.2.

IV. RESULTANT EVENTS

There were no resultant events from this occurrence.

While the plant was shutdown, decay heat was at a minimum level, however, if the plant had been operative, other sources of heat removal would have been available including two other emergency feedwater pumps.

V. PREVIOUS EVENTS OF A SIMILAR NATURE

None

VI. ROOT CAUSE

The root cause was failure of the fuse clip as it was discovered that a fuse holder in the starting circuit had a broken alignment surface. A contributing factor to the reportable event was failure to perform post-maintenance testing.

VII. IMMEDIATE CORRECTIVE ACTION

The broken fuse holder was replaced and the pump was successfully tested.

Control Room Operators involved were cautioned on the necessity to test the pump in the EFW System prior to restoring the component to service following maintenance activities. The remaining crews will also be cautioned on this necessity.

VIII. LONG TERM CORRECTIVE ACTION

The preventive maintenance procedure for pump oil change will be revised to clearly reflect post-maintenance testing requirements.

IX. COMPONENT FAILURE DATA

Westinghouse 30 amp, 250V, 2 pole fuse block style #784A547H02.



GPU Nuclear Corporation
Post Office Box 480
Route 441 South
Middletown, Pennsylvania 17057-0191
717 944-7621
TELEX 84-2386
Writer's Direct Dial Number:

November 23, 1983
5211-83-347

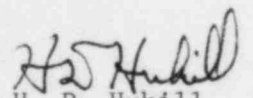
Dr. Thomas E. Murley
Region I, Regional Administrator
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Dear Sir:

Three Mile Island Nuclear Station, Unit 1 (TMI-1)
Operating License No. DPR-50
Docket No. 50-289
LER 83-043/01T-0

This letter transmits Licensee Event Report (LER) No. 83-043/01T-0 which deals with Motor Driven Emergency Feedwater Pump failure to start. Public health and safety were unaffected. This report is being submitted late in accordance with a discussion with NRC Region I Duty Officer Ron Bellamy on November 21, 1983.

Sincerely,


H. D. Hukill
Director, TMI-1

HDH:MRK:vjf

Attachments

cc: R. Conte
Document Management Branch

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