



**Northeast  
Nuclear Energy**

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The Northeast Utilities System

JUN - 6 2000

Docket No. 50-336  
B18133

Re: 10 CFR 50.73(a)(2)(iv)

U.S. Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, DC 20555

Millstone Nuclear Power Station, Unit No. 2  
Licensee Event Report 2000-008-00  
Auto Start of "A" Emergency Diesel Generator  
During Loss of Normal Power Test Restoration

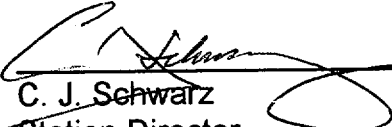
This letter forwards Licensee Event Report (LER) 2000-008-00, documenting an event that occurred at Millstone Nuclear Power Station, Unit No. 2, on May 7, 2000. This LER is being submitted pursuant to 10 CFR 50.73(a)(2)(iv).

Due to the complexity of this event and the time required to perform a thorough investigation, a supplement to this LER will be issued to document the conclusion of the investigation for this event.

There are no regulatory commitments contained within this letter.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

  
C. J. Schwarz  
Station Director

Attachment (1): LER 2000-008-00

cc: H. J. Miller, Region I Administrator  
J. I. Zimmerman, NRC Project Manager, Millstone Unit No. 2  
D. P. Beaulieu, Senior Resident Inspector, Millstone Unit No. 2

JE22

Docket No. 50-336  
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Attachment 1

Millstone Nuclear Power Station, Unit No. 2

LER 2000-008-00

June 2000

**LICENSEE EVENT REPORT (LER)**

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

<b>FACILITY NAME (1)</b> Millstone Nuclear Power Station Unit 2	<b>DOCKET NUMBER (2)</b> 05000336	<b>PAGE (3)</b> 1 OF 3
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**TITLE (4)**  
Auto Start of "A" Emergency Diesel Generator During Loss of Normal Power Test Restoration

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 NAME	DOCKET NUMBER
05	07	2000	2000	-- 008	-- 00	06	06	2000	FACILITY NAME	DOCKET NUMBER

<b>OPERATING MODE (9)</b> 6	<b>THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)</b>										
	20.2201(b)			20.2203(a)(2)(v)			50.73(a)(2)(i)		50.73(a)(2)(viii)		
<b>POWER LEVEL (10)</b> 000	20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)		50.73(a)(2)(x)		
	20.2203(a)(2)(i)			20.2203(a)(3)(iii)			50.73(a)(2)(iii)		73.71		
	20.2203(a)(2)(ii)			20.2203(a)(4)			X 50.73(a)(2)(iv)		OTHER		
	20.2203(a)(2)(iii)			50.36(c)(1)			50.73(a)(2)(v)		Specify in Abstract below of in NRC Form 366A		
20.2203(a)(2)(iv)			50.36(c)(2)			50.73(a)(2)(vii)					

<b>LICENSEE CONTACT FOR THIS LER (12)</b>										
<b>NAME</b> R. Joshi, MP2 Acting Regulatory Compliance Supervisor								<b>TELEPHONE NUMBER (Include Area Code)</b> (860) 440-2080		

<b>COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)</b>										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

<b>SUPPLEMENTAL REPORT EXPECTED (14)</b>					<b>EXPECTED SUBMISSION DATE (15)</b>		MONTH	DAY	YEAR	
X	YES (If yes, complete EXPECTED SUBMISSION DATE).				NO			07	01	2000

**ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)**

On May 7, 2000, an inadvertent auto start of the 'A' Emergency Diesel Generator (EDG) occurred during the restoration of the EDG from a facility Loss of Normal Power (LNP) Test which had been terminated.

The cause of this event and corrective actions are being investigated and will be provided in a supplement to this LER.

**LICENSEE EVENT REPORT (LER)**  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
Millstone Nuclear Power Station Unit 2	05000336	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		2000	-- 008	-- 00	

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

I. Description of Event

On May 7, 2000, an inadvertent auto start of the 'A' Emergency Diesel Generator (EDG) [DG] [EK] occurred during the restoration of the EDG from a facility Loss of Normal Power (LNP) Test which had been terminated. At the time of this event, the unit was in mode 6 (Refueling Outage 13).

The LNP test was terminated due to unexpected lifting of RBCCW [CC] relief valves [RV] and due to excessive vibration of a Containment Air Recirculation fan [FAN] [BB]. Operations personnel were in the process of restoring the EDG from the LNP test when the inadvertent EDG start occurred. At the time of the EDG start, the associated 4160V emergency bus had been restored to its normal offsite power source. The EDG start occurred when the EDG local alarm [ALM] reset button was pushed.

The unexpected start occurred due to the ESF emergency bus undervoltage relays (UV) relays [27] still being "locked in" from the low bus voltage signal generated during the LNP test. The termination section of the LNP test procedure did not identify the need to reset the UV relays prior to resetting the EDG local alarm reset button located on the EDG skid. The test procedure specified that the UV relays were to be checked reset after the local alarm reset button had been pushed.

This event is being reported pursuant to the requirements of 10 CFR 50.73(a)(2)(iv), any event that resulted in the manual or automatic actuation of any Engineering Safety Feature (ESF). A prompt report was issued on May 8, 2000 in accordance with 10 CFR 50.72(b)(2)(ii).

II. Cause of Event

The cause of this event is being investigated and will be provided in a supplement to this LER.

III. Analysis of Event

The EDG provides electrical power to supply emergency loads in the power plant in the event the normal and alternate power sources are lost. Due to the plant configuration and duration that the "A" EDG was running, this event had no adverse safety consequences. The other EDG was operable at all times during this event and capable of providing emergency power to the operable train of safety-related equipment. The inadvertent EDG start while in mode 6 did not result in any equipment damage nor did it challenge any other safety systems. Initial evaluation of this event concludes that this event was not safety significant.

IV. Corrective Action

Corrective actions for this event are being developed and will be provided in a supplement to this LER.

**LICENSEE EVENT REPORT (LER)**  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	LER NUMBER (6)			PAGE (3)
Millstone Nuclear Power Station Unit 2	05000336	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 3
		2000	-- 008	-- 00	

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

V. Additional Information

Similar Events

Previous similar events involving unexpected EDG starts include:

LER 1997-027: On August 2, 1997, at approximately 0800 hours, while troubleshooting a blown fuse for the Engineered Safeguards Actuation System actuation Facility 1 Logic Supply 'A', Instrumentation and Control personnel lifted the Diesel Generator Start Signal lead which resulted in an inadvertent start of the 'A' Emergency Diesel Generator (EDG). The lead which had been lifted was required to be re-landed before the EDG could be shutdown. Operations personnel loaded the EDG and shut it down in accordance with the appropriate operating procedures. The cause of this event was a failure to provide adequate detailed instructions for the preparation, review and approval of a troubleshooting plan. As a result of this event, adequate measures will be established to ensure appropriate independent and management review of troubleshooting plans by September 30, 1997.

LER 1995-028: On July 4, 1995, at 2300 hours with the plant in mode 5 and reactor coolant system at 120 degrees F, an inadvertent actuation of Engineered Safety Features (ESF) occurred. This resulted in the starting of both EDGs and actuation of several other ESF components including starting of fans, and stroking of valves. The causes of this event were inappropriate wiring practices which resulted in the generation of electronic noise during surveillance testing and personnel error in the control of troubleshooting. Corrective actions consisted of hardware design changes to reduce the system's susceptibility to electronic noise, plus counseling and/or disciplining of personnel involved in the troubleshooting. Post-installation testing revealed a significant reduction in electronic noise and no further ESF actuations.

Energy Industry Identification System (EIIIS) codes are identified in the text as [XX].