

LICENSEE EVENT REPORT (LER)

APPROVED ONE NO. 3180-0104
EXPIRES - 6/31/85

FACILITY NAME (1)

Indian Point Unit No. 2

DOCKET NUMBER (2)

0 5 0 0 0 2 4 7

PAGE (3)

1 OF 0 3

TITLE (4)

Inadvertant Strip of 480 VAC Vital Bus Loads

EVENT DATE (6)			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 (3)																																				
0	2	1	4	8	9	8	9	-	0	0	1	0	0	0	3	1	6	8	9	0	5	0	0	0	1	1																					
OPERATING MODE (8)		N		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)																																											
POWER LEVEL (10)		1		0		0		20.402(b)										20.406(a)										80.73(a)(2)(iv)										73.71(v)									
						20.406(a)(1)(iii)										80.34(a)(1)										80.73(a)(2)(v)										73.71(v)											
						20.406(a)(1)(iv)										80.34(a)(2)										80.73(a)(2)(vi)										OTHER (Specify in Abstract below and in Test, NRC Form 306A)											
						20.406(a)(1)(iii)										X 80.73(a)(2)(ii)										80.73(a)(2)(vii)(A)																					
						20.406(a)(1)(iv)										80.73(a)(2)(iii)										80.73(a)(2)(vii)(B)																					
						20.406(a)(1)(v)										80.73(a)(2)(iii)										80.73(a)(2)(viii)																					

LICENSEE CONTACT FOR THIS LER (12)

NAME

John D. Koutouzis, Licensing Spec.

TELEPHONE NUMBER

AREA CODE

9 1 4 5 26 - 5 1 2 9

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPHDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPHDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)		NO		EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
		X						

ABSTRACT (Limit to 1400 words, i.e., approximately fifteen single-space typewritten lines) (16)

On February 14, 1989, while the plant was at 100% power, all equipment supplied from 480 VAC vital bus 3A was inadvertently de-energized. While performing work in a Central Control Room (CCR) auxiliary relay rack, a worker caused a relay momentarily to make-up and disconnect equipment associated with bus 3A. Due to the loss of battery charger No. 23, which was the most limiting component, the operators invoked Technical Specification 3.0.1, which requires restoration of equipment within one hour or subsequent plant shutdown. All systems functioned normally and all equipment was restored to service within 45 minutes.

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111

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMS NO. 3160-0104

EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Indian Point Unit No. 2	0 5 0 0 0 2 4 7	8 9	0 0 1	0 0	0 2	0 3

TEXT (If more space is required, use additional NRC Form 366a) (17)

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-loop pressurized water reactor

IDENTIFICATION OF OCCURRENCE:

Inadvertant strip of all 480 VAC Loads on vital bus

REPORTABILITY DETERMINATION DATE:

February 14, 1989

REPORT DUE DATE:

March 16, 1989

REFERENCES:

Significant Occurrence Report 89-87, 89-87A

PAST SIMILAR OCCURRENCE:

None

DESCRIPTION OF OCCURRENCE:

On February 14, 1989 at 1300 hours, Unit No. 2 was operating at 100% power. An electrician was working in auxiliary relay rack, G-5, tie wrapping newly installed wiring. As the wiring was being wrapped it was drawn into a position that caused it to come into contact with auxiliary relay 273 AX11 (bus 3A). The auxiliary relay momentarily made-up and caused all breakers on 480 VAC bus 3A to open and disconnect associated loads.

Operators in the CCR received various alarms indicating the loss of instrument bus No. 23. An operator locally inspected No. 23 battery charger and reported that there were no indicating lights on the battery charger. At this time battery No. 23 was supplying the D.C. load. The operators placed 23 instrument bus on its alternate feed (lighting bus 22 via lighting bus 23) and removed all unnecessary D.C. loads from the battery. Additional investigation of alarms and indications by the operators indicated the loss of three of the six isolated bus duct cooling fans which led to the determination that the following loads were also lost: MCC's 22, 25, lighting bus 22 (automatically transferred to lighting bus 23), 23 component cooling pump and 24 fan cooler unit.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)						PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER						
Indian Point Unit No. 2	0 5 0 0 0 2 4 7 8 9 - 0 0 1 - 0 0	0 3 OF 0 3								

TEXT (If more space is required, use additional NRC Form 366a (17))

DESCRIPTION OF OCCURRENCE: (continued)

The following equipment automatically started: the standby main boiler feed pump oil pump (No. 22) and the main generator D.C. oil pump. The operators recognizing that the 480 VAC bus 3A had been stripped of its normal loads, reset all MCC's and required equipment to their normal configuration.

Upon further review it was determined that during the process of tie wrapping new wiring in the auxiliary rack G-5 an electrician had apparently inadvertently caused a movement of relay 273AX11. Its momentary actuation resulted in the breaker operation.

Work was immediately stopped in the relay rack.

ANALYSIS OF OCCURRENCE:

Based on review and analysis of applicable electrical system schematic diagrams, components required to disconnect did so. Components not required to function (ie, emergency diesel generators) remained in automatic and capable of providing their intended function. At no time were components precluded from being restarted either by automatic start signal or manual operator action.

Due to the loss of No. 23 battery charger and IP2 Technical Specification requirements disallowing operation with any battery charger out of service, the IP-2 Technical Specification requirements were exceeded and operators invoked Technical Specification 3.0.1. The plant was considered to be in a condition prohibited by Technical Specifications.

CAUSE OF OCCURENCE:

The loss of 480 VAC bus 3A loads from undervoltage relay 273AX11 was due to personnel error during the performance of pre-outage work.

CORRECTIVE ACTION:

Immediate corrective action was taken to stop relay rack work and testing in all central control room locations and evaluate the event. Subsequent action was taken by management to heighten the awareness of all supervisors of the need for sufficient in depth review of each job's potential impact on plant performance with workers assigned to tasks in critical plant areas and the need for periodic supervisor visits to each of these job sites to reinforce the awareness of all personnel involved. Supervisors were reminded of the requirements of a complete and thorough turnover of information when shifts or supervisors are rotated.

Stephen B. Bram
Vice President

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March 15, 1989

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 89-01-00

Document Control Desk
U.S. Nuclear Regulatory Commission
Mail Station Pl-137
Washington, DC 20555

The attached Licensee Event Report LER 89-01-00 is hereby submitted in accordance with the requirements of 10CFR50.73.

Very truly yours,



Attachment

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11