

Stephen B. Bram
Vice President

Consolidated Edison Company of New York, Inc.
Indian Point Station
Broadway & Bleakley Avenue
Buchanan, NY 10511
Telephone (914) 737-8116

March 30, 1991

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 91-05-00

Document Control Desk
US Nuclear Regulatory Commission
Mail Station P1-137
Washington, DC 20555

The attached Licensee Event Report LER 91-05-00 is hereby
submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,



Attachment

cc: Mr. Thomas T. Martin
Regional Administrator - Region I
US Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Francis J. Williams, Jr., Project Manager
Project Directorate I-1
Division of Reactor Projects I/II
US Nuclear Regulatory Commission
Mail Stop 14B-2
Washington, DC 20555

Senior Resident Inspector
US Nuclear Regulatory Commission
PO Box 38
Buchanan, NY 10511

9104080011 910330
PDR ADCK 05000247
S PDR

IE22

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

NRC Form 366 (6-89)

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

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

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Inadvertent trip of 6.9 kv breaker ST5 resulting in loss of power on 480V buses and initiating diesel auto-start.

EVENT DATE:

February 28, 1991

REPORT DUE DATE:

March 30, 1991

REFERENCES:

Significant Event Reports (SOR) 91-118

PAST SIMILAR OCCURRENCE:

July 13, 1984; SOR 85-220, LER 84-008

DESCRIPTION OF OCCURRENCE:

On February 28, 1991, at 0750 hours, with the unit in cold shutdown for refueling, 6.9 kv bus 5 normal feed breaker ST5 tripped open. The cause of the breaker trip could not be determined since no relay target indicators were observed. Maintenance personnel had been working in the 6.9 kv switchgear area around the time of the trip.

The loss of 6.9 kv bus 5 resulted in the loss of 6.9 kv bus 2 which was being fed from bus 5 through a tie breaker. As a result, power was lost to 480V buses 5A and 2A. This initiated an automatic start of Emergency Diesel Generators (EDG's) #22 and #23, and approximately 30 seconds after the initial event, caused Station Service Transformer 5 supply breaker SS5 and Station Service Transformer 2 supply breaker SS2 to trip open due to actuation of time delay relays 27-5/62 and 27-2/62. At the time EDG #21 was tagged out-of-service for maintenance. The EDG's did not pickup the 480V buses because the unit trip lock-out relays were reset. Loss of either 480V bus 5A or 6A in conjunction with a unit trip is required to load the 480V buses on the diesel when no Safety Injection (SI) signal is present.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

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

Service Water Pump #24 and Component Cooling Water Pump #21 were deenergized as a result of the power loss on the 480V buses. The operator started Service Water Pump #25, and approximately 2 minutes after the initial incident, he reclosed Breakers ST-5, SS-5 and SS-2 re-energizing the 6.9 kv and 480V buses. Associated lighting and Motor Control Centers were reset, and pump configuration was returned to the condition prior to the incident. EDG #22 and #23 were shutdown and placed in auto at 0810 hours.

ANALYSIS OF OCCURRENCE:

This report is being made because actuation of an Engineered Safeguards Features System (ESF) occurred. Any manual or automatic actuation of an ESF is reportable under 10 CFR 50.73(A)(2)(iv). There were no adverse safety implications as a result of this event. All safeguards actuations features performed as expected. This event did not cause a loss of decay heat removal capability, any injury of personnel or any damage to equipment.

CAUSE OF OCCURRENCE:

When the breaker tripped, there were no relay targets which indicated the cause of the trip or confirmed the breaker opening to the operator. At the time of the trip a periodic maintenance procedure was being performed on other breakers in the 6.9 kv switchgear area. These breakers are normally removed from the area to perform maintenance. This could not be accomplished due to tagouts which restricted movements in and out of the already cramped 6.9 kv area. An interview with personnel at the time of the event was inconclusive as to the exact cause of the trip. Determination of the most probable cause was reached by the process of elimination. There were no flags confirming the opening of Breaker ST-5, a disturbance on the 138 kv system would have sent a signal for Breaker ST-6 to open (none was received), and ST-5 remained closed when it was returned to service. These facts lead to the conclusion that the most probable cause of the breaker trip was an inadvertent bumping of the breaker cubicle during the performance of periodic maintenance on an adjacent breaker.

CORRECTIVE ACTION:

As an immediate corrective action, the Senior Watch Supervisor (SWS) reminded the individuals working in the 6.9 kv area of the need to exercise caution when working around plant equipment since bumping relays could cause breaker trips that could potentially lead to reactor trips. Training will ensure that their programs stress the importance of personnel attentiveness to the consequences of bumping into plant components.