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August 1, 1997

Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER 97-016-00

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

The attached Licensee Event Report 97-016-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,

*Thomas Schmeier*

Attachment

cc: Mr. Hubert J. Miller  
Regional Administrator - Region I  
US Nuclear Regulatory Commission  
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King of Prussia, PA 19406

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Division of Reactor Projects I/II  
US Nuclear Regulatory Commission  
Mail Stop 14B-2  
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LICENSEE EVENT REPORT (LER)

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 No. 2						DOCKET NUMBER (2) 0   5   0   0   0   2   4   7			PAGE (3) 1   OF   0   4		
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TITLE (4) Auto-Start of Emergency Diesel Generators																									
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 NAMES		DOCKET NUMBER(S)														
0	7	0	2	9	7	9	7	-	0	1	6	-	0	0	0	8	0	1	9	7	0	5	0	0	0

OPERATING MODE (9) N		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: (Check one or more of the following) (11)																																						
POWER LEVEL (10) 0   0   0	20.402(b)		20.405(a)(1)(i)		20.405(a)(1)(ii)		20.405(a)(1)(iii)		20.405(a)(1)(iv)		20.405(a)(1)(v)		20.405(c)		50.36(c)(1)		50.36(c)(2)		50.73(a)(2)(i)		50.73(a)(2)(ii)		50.73(a)(2)(iii)		X 50.73(a)(2)(iv)		50.73(a)(2)(v)		50.73(a)(2)(vii)		50.73(a)(2)(viii)(A)		50.73(a)(2)(viii)(B)		50.73(a)(2)(x)		73.71(b)		73.71(c) OTHER (Specify in Abstract below and in Text, NRC Form 336A)	

LICENSEE CONTACT FOR THIS LER (12)																	
NAME James J. Maylath, Senior Engineer								TELEPHONE NUMBER									
								AREA CODE		9   1   4		7   3   4		-   5   3		5   6	

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)														
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)								EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)						X NO						

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

On July 2, 1997, with the unit at hot shutdown, 480V Bus 3A was inadvertently de-energized. This caused the three Emergency Diesel Generators (EDGs) to start and Auxiliary Feedwater Pump (AFP) 21, which was running at that time, to trip. At the time of this event, 480V Bus 3A was being supplied from 480V Bus 2A through a tie breaker. The normal supply breaker for Bus 3A was tagged out due to maintenance. The tie breaker between Buses 2A and 3A was erroneously tripped by a mechanic who was working on an adjacent breaker cubicle. Following the event, the tie breaker between Buses 2A and 3A was reclosed and Bus 3A was re-energized. AFP 21 was restarted and the EDGs were secured and returned to automatic status.

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TEXT CONTINUATION**

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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:**

Automatic Start of Emergency Diesel Generators

**EVENT DATE:**

July 2, 1997

**REPORT DUE DATE:**

August 1, 1997

**REFERENCES:**

Condition Identification and Tracking System (CITRS) No. 97-E02634

**PAST SIMILAR OCCURRENCE:**

LER 93-002

**DESCRIPTION OF OCCURRENCE:**

On July 2, 1997 at 2105 hours, with the Reactor Coolant System (RCS) temperature at 345°F and RCS pressure at 1,013 psig, 480V Bus 3A was inadvertently de-energized. The de-energization of Bus 3A actuated the 480V bus undervoltage logic which automatically started the three Emergency Diesel Generators (EDGs). The de-energization of Bus 3A also caused Auxiliary Feedwater Pump (AFP) 21, which was running at that time, to trip. AFP 21 is supplied by Bus 3A, and upon de-energization of the bus, AFP 21 automatically tripped.

At the time of this event, 480V Bus 3A was being supplied from 480V Bus 2A through Breaker 52/2AT3A. Breaker 52/3A which is the normal supply breaker

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for Bus 3A was tagged out due to maintenance. Breaker 52/2AT3A was erroneously tripped by a mechanic who was working on Breaker 52/2AT5A which is located in the breaker cubicle directly above the cubicle for Breaker 52/2AT3A.

Following the event, Breaker 52/2AT3A was reclosed, and Bus 3A was re-energized. AFP 21 was restarted, and the EDGs were secured and returned to automatic status.

**ANALYSIS OF OCCURRENCE:**

This report is being made because actuation of an Engineered Safety Feature occurred. Any unplanned 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 ESFs performed as expected. This event did not cause any injury to personnel or damage to equipment.

**CAUSE OF OCCURRENCE:**

A mechanic who was working on Breaker 52/2AT5A inadvertently tripped Breaker 52/2AT3A. When the mechanic bent his knees, one of his knees inadvertently depressed the trip button for Breaker 52/2AT3A which is mounted on a box that protrudes approximately six inches from the front of the Breaker 52/2AT3A cubicle.

Prior to working in the Breaker 52/2AT5A cubicle, the personnel involved received a pre-job briefing. However, this briefing only focused upon personnel safety and not upon interfaces with equipment in close proximity to where the work was being performed. The root cause of this event is worker error on the part of the mechanic who was working in the Breaker 52/2AT5A cubicle compounded by not considering the consequences of potential worker errors at the work location during the pre-job briefing.

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**CORRECTIVE ACTION:**

Following operator verification that 480V Bus 3A was erroneously de-energized, Breaker 52/2AT3A was reclosed, and Bus 3A was re-energized. AFP 21 was restarted, and the EDGs were secured and returned to automatic status.

Inadvertent bumping of breaker cubicles or relay panels has occurred during previous refueling outages when there is typically a significant amount of electrical work being performed. Following these previous events, the STAR Program (STOP-THINK-ACT-REVIEW) was implemented. Further emphasis of the STAR Program including the significance of the possible adverse consequences of bumping into plant equipment will be made in continuing training sessions.

The potential consequences of worker errors for work in areas where there is sensitive equipment such as site power supplies will be evaluated by the appropriate planning organizations and discussed during pre-job briefings with the organizations that are performing the work. Particular attention will be paid to conditions such as protruding boxes or handles.