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SUBJECT: LER 89-002-00:on 890308,automatic initiation of reactor bldg emergency ventilation due to loss of I&C Bus 130.

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NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Nine Mile Point Unit 1	0 5 0 0 0 2 2 0	1 OF 0 9

TITLE (4) Automatic Initiation of Reactor Building Emergency Ventilation Due to Loss of I&C Bus 130

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 5 0 0 0
0 3	0 8	8 9	8 9	— 0 0 2	— 0 0	0 4	0 7	8 9		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(c)	X 50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Robert G. Randall, Operations Superintendent	3 1 5 — 3 4 9 — 2 4 4 5

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	
D	E A	R L Y	G 0 8 0	No							

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)

ABSTRACT

On March 8, 1989, with the mode switch in "SHUTDOWN" and Nine Mile Point Unit 1 in an extended refueling outage with the core off-loaded, the Reactor Building Emergency Ventilation System (RBEVS) was initiated due to a momentary loss of power to the Instrument and Control (I&C) Bus 130. This loss of power tripped the Refuel Floor High Radiation Monitor, and with the keylock switch for the monitor in the "REFUEL" position, this resulted in RBEVS initiating as designed. On March 11, 1989 the RBEVS was again initiated when the Refuel Floor Radiation Monitor tripped due to a momentary loss of power to the I&C Bus 130.

The root cause for the March 8 event was equipment failure due to procedural deficiency. This led to a spurious alarm for reserve transformer 101N, and ultimately a loss of power during operational efforts to remove the transformer from service. Root cause for the March 11 event is personnel error due to cognitive error and procedural deficiency. In returning the 101N reserve transformer to service, after the March 8 event, the Control Room Operators inadvertently initiated a loss of power during their Control Room switching operations.

Immediate corrective actions taken as a result of the March 8 and March 11 auto-initiation of RBEVS consisted of resetting the 86-16 lockout device and restoring power to powerboard 16B. After restarting the normal loads powered from powerboard 16B, RBEVS was returned to a standby condition. In addition, subsequent corrective actions have been taken or will be initiated to address all contributing factors to these events.

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

DESCRIPTION OF THE EVENTS

On March 8, 1989, with the mode switch in "SHUTDOWN" and Nine Mile Point Unit 1 in an extended refueling outage with the core off-loaded, the Reactor Building Emergency Ventilation System (RBEVS) was initiated due to a momentary loss of power to the Instrument and Control (I&C) Bus 130. This loss of power tripped the Refuel Floor High Radiation Monitor, and with the keylock switch for the monitor in the "REFUEL" position, this resulted in RBEVS initiating as designed.

The undervoltage condition was initiated by the following sequence of events. At 1517 hours, the sudden pressure fault relay alarm was received in the Control Room for reserve station service transformer 101N. The initial operator actions were to remove the transformer from service. At the time, 101N was providing normal feed to emergency powerboard 102, which can also be fed from emergency diesel generator 102 in the event the offsite feed through the 101N transformer is lost. However, the emergency diesel generator was out-of-service for maintenance. Therefore, the switching operations required in the Control Room to isolate 101N resulted in de-energizing powerboard 102. Undervoltage protection relaying on powerboard 102 immediately tripped open its normal feeder breaker (R1012) from reserve transformer 101N as well as energizing the 86-16 lockout device, which tripped off Reactor Building Closed Loop Cooling pump 13 and Fuel Pool Circulating pump 11. Since the "B" section of powerboard 16 was being fed by powerboard 102 it also immediately de-energized. Powerboard 167, which is normally fed by powerboard 16B, is a "swing" bus that will automatically transfer its feed to powerboard 17B if 16B voltage is lost. It feeds distribution panel 167A which in turn was providing a feed to I&C Bus 130. By design, the auto-transfer device has a one second time delay built in for momentary undervoltage conditions. When powerboard 167 transferred its feed from powerboard 16B to powerboard 17B, the 130 bus experienced a momentary loss of power. This was sufficient to trip the Refuel Floor High Radiation Monitor, and combined with the keylock switch (located on the Control Room back panel) being in the "REFUEL" position, resulted in tripping off of the Reactor Building Normal Ventilation System and initiation of RBEVS. Due to power availability, only RBEVS Fan 12 started initially.

The immediate operator actions were to re-energize powerboard 16B by opening the normal feed breaker (R1043) and closing the crosstie breaker (R1042) to powerboard 16A, which was energized via the 345kv backfeed established through station service transformer T10 and powerboard 11. Upon closing, the R1042 breaker immediately tripped open because the 86-16 lockout device had not been reset, nor had the interlocks been met to reset the device (undervoltage not present on powerboard 102, i.e. diesel running, or the R1012 breaker in pull-to-lock). The operators recognized their error, established the required breaker lineup, reset the 86-16 lockout device, and successfully re-energized powerboard 16B via the crosstie. This resulted in starting up of RBEVS Fan 11 (initially idle due to no power to powerboard 161B) and Control Room Emergency Ventilation Fan 11, whose initiation logic had been armed by the initial de-energization of powerboard 1671A (fed by 16B). At 1545 hours, the RBEVS was restored to standby condition, as well as Control Room Emergency Ventilation Fan 11.

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

The Fuel Pool Circulating pump 11 was restarted and Computer Power Supply MG set 167 (being used to charge Battery 11) was returned to service. The unit resident NRC inspector was informed and telephone notification of the event made at 1742 hours in accordance with 10CFR50.72.

On March 11, 1989 the RBEVS was again initiated when the Refuel Floor Radiation Monitor tripped due to a momentary loss of power to the I&C Bus 130. This event was initiated when Operators were attempting to restore power to powerboard 102 following corrective maintenance on reserve transformer 101N associated with the March 8 event. The transformer had already been energized and operations was preparing to close the normal feeder breaker (R1012 was in pull-to-lock) to powerboard 102. At the time, powerboard 16B was still being fed by powerboard 16A via crosstie breaker R1042. At approximately 2011 hours, the operator closed breaker R1012 which immediately resulted in undervoltage protective relaying (relay 27X-1 specifically) energizing the 86-16 lockout device, which tripped the crosstie breaker R1042 and de-energized powerboard 16B. From this point the automatic actions taking place were the same as the March 8 event with the end result being initiation of RBEVS due to the time delay associated with powerboard 167's auto-transfer to powerboard 17B. The reason the undervoltage protective relaying energized the 86-16 lockout device was due to the control switch for the R1012 breaker passing through the "neutral" position during its closing action. With no voltage on powerboard 102 (the breaker hadn't closed yet) the conditions were met for energizing relay 27X-1, and thus the lockout device.

The initial Operator Corrective Actions were to immediately close both feeder breakers to powerboard 16B from powerboard 102 (R1021 and R1043), and to reset the 86-16 lockout device. With power restored to 16B, Reactor Building Emergency Ventilation Fan 11 and Control Room Emergency Ventilation Fan11 auto-started. Both the Control Room and Reactor Building Emergency Ventilation System were restored approximately 5 minutes after their initiation. Telephone notification to the NRC in accordance with 10CFR50.72 was made at 2130 hours.

In both events, the plant process computer was lost when I&C Bus 130 experienced its momentary loss of power. This was caused by the computer power supply panel being lined up with Bus 130 instead of the Computer Power Supply MG set.

CAUSE OF THE EVENT

A root cause evaluation of these events was performed in accordance with procedure S-SUP-1, "Root Cause Evaluation Program". In both events, the cause for the auto-initiation of RBEVS was due to the momentary loss of power to the Refuel Floor High Radiation Monitor. However, the root cause that resulted in this undervoltage condition in each event is different, even though the events share several contributing factors.

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

The root cause for the March 8 event is equipment failure due to procedural deficiency. The sudden fault pressure relay alarm that was received in the 101N reserve transformer required Operations to immediately remove the transformer from service. Subsequent investigation of the alarm by electricians revealed that a combination of ice and moisture had built up in a terminal box (at the transformer), resulting in a spurious alarm. No transformer fault condition was actually experienced. The space heater in the terminal box had stopped working due to a failed fuse. The reserve transformers are inspected on a daily basis per electrical preventive maintenance procedure N1-EPM-GEN-D290, "Daily Outdoor Transformer and Switchyard Checks". As part of these inspections, the space heaters in the control cabinets associated with the transformers are checked. However, the heater in this particular terminal box, which along with alarm wiring terminations also contains the current transformer leads, is not checked as part of that inspection. The procedure is incomplete in failing to identify this heater (and its location) as part of those required to be checked.

The root cause for the March 11 event is personnel error due to cognitive error and procedural deficiency. In returning the reserve transformer to service and preparing to re-energize powerboard 102 by closing the R1012 feeder, the Control Room Operators did not believe this action would result in any automatic actuations (i.e., energizing the 86-16 lockout device and tripping the crosstie between powerboard 16A and 16B). A very significant factor was a conflict between two operating procedures for the equipment involved in this operation. N1-OP-33A, 115kv Service, has instructions for returning the reserve transformer to service that assume that powerboard 102 is already energized via a backfeed from powerboard 16B (and 16A) when performing the required switching operations. This was not the case (powerboard 16B was not backfeeding 102 - this is the configuration the systems had been left in when removing the 101N reserve transformer from service on March 8). N1-OP-30, 4.16 kv, 600v, and 480v House Service, provides instructions for placing powerboard 102 in service and also contains a caution to not establish a backfeed through powerboards 16A and 16B to powerboard 102. The operators saw that the existing electrical board line-ups were in agreement with that caution statement and not in agreement with N1-OP-33A's instructions and decided to follow N1-OP-30's instructions when they had reached the point to actually re-energize powerboard 102. However, these instructions do not discuss or caution the operator about the relationship between the R1012 breaker control switch, the undervoltage protective relaying and the 86-16 lockout device (which, historically, was the intent behind the instructions found in N1-OP-33A that maintain powerboard 102 energized with a backfeed when removing a reserve transformer for maintenance, thus preventing a trip like the one experienced). The procedural deficiencies present in both N1-OP-33A and N1-OP-30, combined with the operators' assumptions, resulted in the momentary de-energization of powerboard 16B and subsequent auto-initiation of RBEVS.

There were several contributing factors to both events. These include the following:

1. Due to maintenance activities during the present outage, a number of off normal electrical lineups are presently established. I&C Bus 130 was being fed by its alternate power supply due to maintenance associated with its normal supply (powerboard 13B). The alternate power supply, provided by powerboard 167 through distribution panel 167A, introduced the time-delay auto-transfer device into the lineup supplying the refuel floor high range radiation monitor. The device performed as designed, however, the monitor cannot sustain a momentary loss of power, even if it is for only one second.
2. During the March 8 event, the operators efforts were complicated by (a) the unavailability of EDG 102 (due to maintenance), (b) the uncertainty of the reserve transformer status, and (c) a deficient alarm response procedure (for the sudden pressure fault alarm). The alarm response found in operating procedure N1-OP-30, "4.16kv, 600v, and 480v Service", directs the operators to remove the transformer from service without providing any instructions on how to do this. The procedure also assumes that the EDG is available to maintain powerboard 102 energized. The instructions for removing the reserve transformer from service are found in N1-OP-33A, "115kv Service", and are for a maintenance condition, not an emergency condition. The operators, working under pressure to de-energize the transformer as directed by the alarm response, had to de-energize powerboard 102 (and consequently powerboard 16B).
3. The operating shift on duty during the March 11 event had not been informed about the March 8 initiation of RBEVS by their shift supervisor, who in turn, had not been adequately briefed about the event during a shift turnover on March 9. Had they been aware of the cause of the initiation, they might have exercised more caution in their efforts to re-energize powerboard 102.

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ANALYSIS OF THE EVENT

These events are considered reportable in accordance with 10CFR50.73 (a)(2)(iv), "Any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS). However, actuation of an ESF, including the RPS, that resulted from and was part of the pre-planned sequence during testing or reactor operation need not be reported".

There were no adverse safety consequences as a result of these events. The plant was in a cold shutdown condition with fuel off-loaded from the core and no other refueling related activities taking place. The initiation of the RBEVS is the protective mode of operation and, thus, it performed its intended safety function. In both events, there existed a period of time where the fan on one train (#11) of Reactor Building Emergency Ventilation was inoperable till powerboard 16B was re-energized. However, the design of the system is such that the redundant fan (#12) and its train can provide 100% of the filtering requirements.

Had the March 8 or March 11 sequence of events occurred during full power operation (assuming that emergency diesel generator 102 was out of service and powerboard 102 and 16B were de-energized purposely or inadvertently), initiation of RBEVS would still be a conservative action and not pose a challenge to the safety or operation of the plant. The operational response would be the same as that during both events; directed towards resetting the 86-16 lockout device and restoring power to powerboard 16B, followed by restart of the required loads to support power operation (RBCLC pump 13, etc.). It should be emphasized that each of the system/components required for safe shutdown that are fed by powerboards 102 or 16B has a redundant system/component that can be powered from powerboards 103 or 17B via the reserve transformer 101S or emergency diesel generator 103. Therefore, there would not be any adverse safety consequences at full power.

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CORRECTIVE ACTIONS

Immediate corrective actions taken as a result of the March 8 and March 11 auto-initiation of RBEVS consisted of resetting the 86-16 lockout device and restoring power to powerboard 16B. After restarting the normal loads powered from powerboard 16B, the RBEVS and CREVS were returned to a standby condition. Subsequent corrective actions taken include the following:

1. At the local terminal box on the 101N reserve transformer, the ice and moisture was removed and the blown fuse was replaced, which returned the air space heater to service. In addition, several conduits entering the box that are routed underground (and thus, a potential source of moisture) were sealed with an approved sealant. Another task performed was an inspection of this same terminal box on the 101S reserve transformer. The heater fuse was found blown and was replaced. Electrical maintenance will revise the electrical preventive maintenance procedure that performs the daily check of the transformers to verify that these heaters are properly working during cold weather. This can be done by placing your hand against the outer cover.
2. All shifts received training in the area of procedure adequacy and compliance subsequent to the March 11 event. This guidance was formally issued as Station General Order 89-03 on March 17, 1989. This order directs personnel to stop activities when procedural deficiencies are identified and take corrective actions to resolve these deficiencies before continuing.
3. Operations will revise N1-OP-30 and N1-OP-33A to ensure that both procedures are consistent in their instructions associated with removing and returning to service the reserve transformers, the emergency powerboards (102 and 103) and the 600v emergency powerboards (16 and 17). This will include revising the alarm response procedure for a sudden fault pressure condition. In addition, the alarm response procedures for this condition will be reviewed with respect to other major Unit 1 transformers. Another element of this revision will be the use of a special switching order for maintenance situations requiring removal and restoration of a reserve transformer or an emergency powerboard. This will enable operations to address any special conditions that might be present at the time maintenance is required on the equipment.
4. Training Modification Request #01-89-35 was generated to review electrical interlocks associated with the reserve transformer switching (115kv bus) and powerboard breakers. Operator actions on March 8 and March 11 indicate a need to review these interlocks.

5. A Lessons Learned transmittal will be generated to summarize and review operator actions during both the March 8 and March 11 events. The importance of informing all shifts of operational events that occur will be emphasized (via shift turnover, shift logs, and night orders). In addition, the transmittal will stress the importance of control room operators being cognizant of plant electrical lineups and equipment status, to facilitate evaluating plant impact during operational events.

ADDITIONAL INFORMATION

This event is similar to an event described in NMP-1 LER 86-08, dated May 21, 1986. In that event RBEVS was initiated due to loss of power to I&C Bus 130, which resulted in tripping of the Refuel Floor High Radiation Monitor. Bus 130 was lined up with its normal feed from powerboard 13B, which in turn was being fed by powerboard 12 and the 345kv backfeed established during refueling outages. The loss of power occurred due to maintenance activities related to the backfeed and a failure of powerboard 12 to auto-transfer to reserve transformer 101S when the backfeed was lost. Corrective actions taken as a result of LER 86-08 were directed at the auto-transfer failure, and thus could not have prevented the events described in this LER.

The following table lists the identifier codes of the involved equipment according to IEEE 805-1983, IEEE 803A-1983, and Table 9 of the NPRDS Reporting Procedures Manual.

EPN	Component	Model Number	IEEE-805 System	IEEE-803 Component	NPRDS Table 9 Manufacturer
-	Fuse	6 AMP	EA	FU	-
-	Heater	-	EA	EHTR	-
101N	Transformer		EA	XFMR	G080
-	Automatic Transfer Switch	247A3330	EA	ASU	A4999
R015C-10	Radiation Monitor	129B280262	IL	MON	G080
-	Fault Pressure Relay Types	-	EA	RLY	G080

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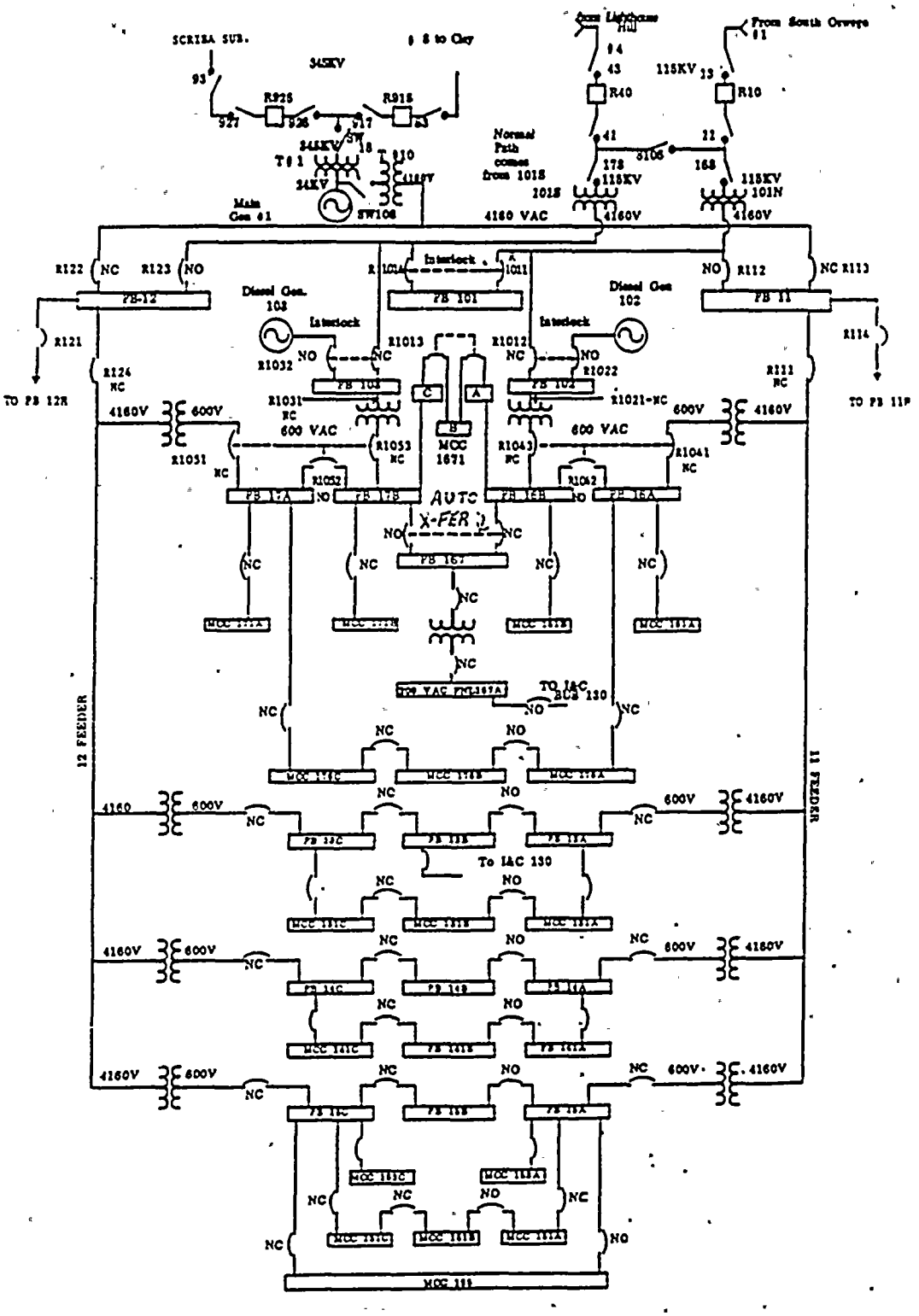

MAIN POWER DISTRIBUTION SYSTEM

NIAGARA MOHAWK

NMP49008

NINE MILE POINT NUCLEAR STATION / P.O. BOX 32 LYCOMING, NEW YORK 13093 / TELEPHONE (315) 343-2110

April 7, 1989

United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Re: Docket No. 50-220
LER 89-02

Gentlemen:

In accordance with 10 CFR 50.73, we hereby submit the following Licensee Event Report.

LER 89-02 Which is being submitted in accordance with 10 CFR 50.73 (a)(2)(iv), "Any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS). However, actuation of an ESF, including the RPS, that resulted from and was part of the preplanned sequence during testing or reactor operation need not be reported."

Two 10 CFR 50.72 reports were made, the first at 1742 hours on March 8, and the second at 2130 hours on March 11.

This report was completed in the format designated in NUREG-1022, Supplement 2, dated September 1985.

Very truly yours,

James L. Willis
General Superintendent
Nuclear Generation

JLW/RC/cb
(0407V)

Attachment

cc: William T. Russell
Regional Administrator

Cert No.
P967928957
IE22
1/1