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10 CFR 50.73

September 7, 1990 MN-90-87 SEN-90-252

UNITED STATES NUCLEAR REGULATORY COMMISSION Attention: Document Control Desk Washington, D. C. 20555

References: (a) License No. DPR-36 (Docket No. 50-309)

Subject: Maine Yankee Licensee Event Report 90-002-01 - Inadvertent SIAS While Swapping Vital AC Busses

Gentlemen:

Please find enclosed Maine Yankee Licensee Event Report 90-002-01. This report is submitted in accordance with the requirements of 10 CFR 50.73(a)(2)(iv).

Please contact us should you have any questions regarding this matter.

Very truly yours,

SENicher

S. E. Nichols Licensing Section Head

SEN: SJJ

Enclosure

c: Mr. Thomas T. Martin Mr. Eric J. Leeds Mr. Charles S. Marschall Mr. Patrick J. Dostie

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Level	0       0       -       20.405(a)(1)(ii)       -       50.36(c)(2)       -       50.73(a)(2)(vii)       -       Dother (Specify Abstract below and in Text, NR(1)         -       20.405(a)(1)(iv)       -       50.73(a)(2)(ii)       -       50.73(a)(2)(viii)(A)       -       Abstract below and in Text, NR(1)         -       20.405(a)(1)(v)       -       50.73(a)(2)(iii)       -       50.73(a)(2)(viii)(A)       -       Abstract below and in Text, NR(1)         -       20.405(a)(1)(v)       -       50.73(a)(2)(iii)       -       50.73(a)(2)(viii)(B)       -       And in Text, NR(1)         -       20.405(a)(1)(v)       -       50.73(a)(2)(iii)       -       50.73(a)(2)(viii)(B)       -       Form 366A)         LICENSEE CONTACT FOR THIS LER (12)         Telephone Number         Area Code         2       0       7       6       8       2       6       3       2       1         Complete Nuclear Safety Engineer         Comment Uneer to NPRDS         Comment Wanufac- Reportable         Comment turer to NPRDS         Supplemental Report Expected (14)         Supplemental Report Expected (14)       Expected Month	Level	Power			20.	.40	5(0)(	1)(1)	1	_ 50	.36(	c)(1)		- 50	).73	3(a)	(2)	(+)			1	73.	710	c)		
-       20.405(a)(1)(iv)       -       50.73(a)(2)(11)       -       50.73(a)(2)(vii1)(B)       and in Text         20.405(a)(1)(v)       -       50.73(a)(2)(11)       -       50.73(a)(2)(x)       Form 366A)         LICENSEE CONTACT FOR THIS LER (12)         NAME         Telephone Number         Area Code         2       0       7       8       6       2       6       16       12       16       13         Complete To ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)         Com- Manufac- Reportable         Com- Manufac- Report Expected (14)         Expected Month Day         Supplemental Report Expected (14)         Expected Month Day         Supplemental Report Expected (14)         Expected Month Day         Submission Date)         (1 f yes, complete Expected         XI No	-       20.405(a)(1)(iv)       -       50.73(a)(2)(11)       -       50.73(a)(2)(viii)(B)       and in Text, NRI         20.405(a)(1)(v)       -       50.73(a)(2)(1ii)       -       50.73(a)(2)(x)       Form 366A)         LICENSEE CONTACT FOR THIS LER (12)         Telephone Number         Area Code         2       0       7       6       6       2       6       12       12       12         COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)         Com- Manufac- Reportable         Com- Manufac- Reportable         ponent turer to NPRDS         Supplemental Report Expected (14)         Expected Month Day Year         Supplemental Report Expected (14)         Expected Month Day Year         mit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)         , 1990 while in a refueling shutdown condition, an inadvertent actuation of Engineer         as alternate power for the inverter. 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U.S. Nuclear Regulatory Commission Approved OMB No. 3150-0104 (9-83) Expires: 8/31/85 LICENSEE EVENT REPORT (LER) TEXT CONTINUATION Facility Name(1) Docket Number(2) LER Number (6) Page(3) Year Revision Sequential Number Maine Yankee Atomic Power Company Number 01012 015101010131019 910 0 TEXT (If more space is required, use additional NRC Form 366A's) (17)

At 2307 on April 14, 1990, while in a refueling shutdown condition, an inadvertent actuation of safeguard systems occurred. The 120 volt AC vital (EF) busses (BU) #1 and #4 were being powered from inverter #1 (INVT) to allow maintenance on inverter #4. See attached diagram. While returning the #4 inverter to service, a licensed operator incorrectly opened the normal supply breaker (BKR) for bis 1. This action simultaneously de-energized both vital AC busses #1 and #4. Both trains of Safety Injection (JE) actuated at the instant both vital busses were de-energized. There were no significant adverse effects on plant operation since the plant was in a refueling shutdown condition with the diffected safety systems secured. Inverter #1 was returned to service and the sat guaro \_ anal were reset.

It was immu finitely determined that the wrong breaker had been opened and was the cause of the in was imment thely determined that the wrong breaker had been opened and was the cause of the inadvertent sa equard actuation. As the diagram indicates, AC vital busses #1 and #4 can be cross-tied to either inverter #1 or #4. The cross-tie is accomplished by a set of mechanically interlocked breakers that require disconnecting the vital bus frum one source before connecting to the new source. Power for but #4 was being supplied through the normally open feeder breaker from inverter #1. The procedure directed the opening of the alternate feeder breaker on bus #4 was being to the new source. to intentionally de-energize it prior to closing in its normal feeder breaker from inverter #4. The licensed operator incorrectly opened the normal feeder breaker from inverter #1, simultaneously de-energizing both vital bus #1 and #4.

Due to the fail-safe design of the Engineered Safeguard Feature logic, the loss of power to busses #1 and #4 caused two of the four pressurizer (PZR) pressure channels to de-energize and automatically unblock the associated Safety Injection channels. This satisfied the logic for actuation of Safety Injection Actuation Signal (SIAS) on low pressurizer pressure.

Prior to the occurrence, reactor vessel level had been lowered to six inches below the vessel flange in preparation of reactor head removal. Due to concerns of operating at reduced inventory while on Residual Heat Removal (BP) (RHR), an operable, manual make-up path from the Refueling Water Storage Tank (RWST) to the Reactor Coolant System (AB) (RCS) via the High Pressure Safety Injection (BQ) (HPSI) System was established. All HPSI pumps were in Pull To Lock. Upon actuation of the SIAS logic, automatic valves realigned as designed and allowed a flowpath from the RWST to the RCS by gravity feed. Approximately 400 gallons of borated water was transferred to the RCS, increasing vessel level to two inches below the vessel flange. No water overflowed the vessel. The gravity feed was stopped by operator action to bypass the SIAS signal and close the HPSI header isolation valves.

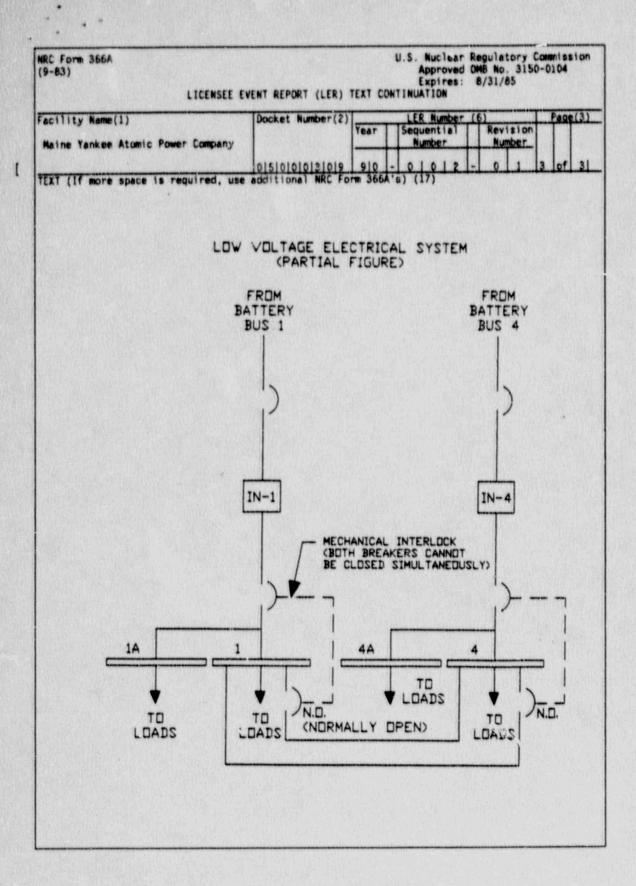
The cause of the inadvertent SIAS was quickly determined, the busses re-energized, and SIAS reset using available procedures. The RHR mode of core cooling was maintained throughout the event.

The SIAS also caused a loss of power to portions of the security access system due to a load shedding sequence associated with the safety injection signal. The items affected include the entrance turnstile, X-ray machine, and explosives detector. All of these entrance process devices can be backed up by manual operations. Security personnel immediately compensated for the loss, negating any potentially adverse effects.

An initial review of the procedures and conditions associated with the inappropriate action identified a weakness in the labeling scheme utilized on the vital bus transfer panels. As an immediate corrective action, the labeling was changed to aid operator identification and indicate the purpose of each breaker on the vital bus transfer panels. Maine Yankee is currently implementing a program to upgrade the labeling on plant components and will provide permanent human factored labeling on the affected transfer panels. Additionally, a root cause evaluation is being performed by the Operations Department.

A similar inadvertent SIAS event was previously reported in LER 84-007.

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