NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: [ ] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01	LICENSEE CODE: M D C C N 1 (2) LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) LICENSE TYPE: 4 1 1 1 1 (4) CAT: (5)
CON'T 01	REPORT SOURCE: L (6) DOCKET NUMBER: 0 5 0 0 0 3 1 7 (7) EVENT DATE: 1 1 0 9 8 2 (8) REPORT DATE: 1 2 0 8 8 2 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal Mode 1 operation at 0946, power was lost to 120 Volt AC
03 vital bus #11 (T.S. 3.8.2.i). A DC feeder breaker to the inverter sup-
04 plying this bus had apparently been inadvertantly tripped open by a con-
05 tractor working in the area. Due to a Feedwater Regulating Valve power
06 supply relay failure, a reactor trip ensued. Power was restored to the
07 bus at approximately 1010. The three redundant 120 V AC vital buses re-
08 mained operable during this event. Similar events: none.

09	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	E D (11)	A (12)	F (13)	C K T B R K (14)	A (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 2	—	0 6 8	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
A (18)	X (19)	A (20)	C (21)	0 0 1 0	Y (23)	N (24)	X (25)	E 3 5 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of the loss of the 120 Volt AC vital instrument bus is be-
11 lieved to have been inadvertant opening of the DC input breaker to the
12 inverter supplying the bus. To prevent recurrence of the event, a modi-
13 fication will be performed to the inverter cabinets to prevent inadver-
14 tant opening of the breakers.

15	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	E (28)	1 0 0 (29)	N/A	A (31)	Operator Observation

16	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z (33)	Z (34)	N/A	N/A

PERSONNEL EXPOSURES

17	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

18	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	N/A

8212210384 821208
PDR ADOCK 05000317
S PDR

LOSS OF OR DAMAGE TO FACILITY (43)

19	TYPE	DESCRIPTION
	Z (42)	N/A

PUBLICITY

20	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)	N/A	

NAME OF PREPARER R. L. Wenderlich/L. Salyards PHONE: 301-269-4776/4972

GPO 917-926

LER NO. 82-68/3L
DOCKET NO. 50-317
LICENSE NO. DPR 53
EVENT DATE 11-09-82
REPORT DATE 12-08-82
ATTACHMENT

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (CONT'D)

During normal Mode 1 operation at 0946 on November 9, 1982, the DC input breaker to the inverter supplying 120 Volt AC vital instrument bus #11 (T.S. 3.8.2.1) was inadvertantly opened, deenergizing the vital instrument bus. Due to the ensuing voltage stepdown transient, #11 4KV bus supply breaker opened on undervoltage. The DC breaker was believed to have been accidently opened by contractor personnel pulling electrical cables in the Cable Spreading Room for Unit 1. These cables were being moved to Unit 1 Cable Spreading Room to supply power to the Unit 2 Auxiliary Feedwater System third train. #11 Diesel Generator started and closed in on #11 4KV bus shortly thereafter, reenergizing the 4KV bus. The loss of the vital AC instrument bus resulted in a loss of the normal power supply to #11 Steam Generator Feedwater Regulating Valve (FRV) control system. The alternate AC supply was not automatically supplied to the FRV control system, due to failure of a power supply relay. The loss of the FRV control system led to a reactor trip on low water level in #11 Steam Generator. The three redundant 120V AC vital buses remained operable during the event. The instrument bus was reenergized at approximately 1010. This is not a repetitive event.

CAUSE DESCRIPTION AND CORRECTIVE ACTION (CONT'D)

The cause of the opening of the DC input breaker to the inverter is believed to have been an electrical cable brushing against the control switch for the breaker. Subsequent testing of the control switch revealed it was easily opened by downward movement of the switch. Due to the quiet operation of the breaker, the contractor personnel were not aware that the breaker had tripped. The power supply relay which failed was replaced and tested. A one-time test will be performed on the redundant bus power supply relays for the FRV control systems for Units 1 and 2 to verify operability. In addition, all operators will be trained on the specifics of this event. These actions will be completed by May 31, 1983. To prevent recurrence of the event, a modification will be performed to the inverter cabinets to prevent inadvertant opening of the DC or AC breakers on these cabinets. A study will be initiated to identify cabinets in the Cable Spreading Room that are susceptible to this type of occurrence.