NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Shoreham Nuclear Power Station Unit #1	0 5 0 0 0 3 2 2	1 OF 0 4

TITLE (4)
Loss of RPS Bus "B" due to personnel error during a tagging operation

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 5	2 8	8 8	8 8	0 0 7	0 0	0 6	2 4	8 8		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
4		20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 1 0 0		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(c)(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
Robert W. Grunseich, Operational Compliance Engineer	AREA CODE 5 1 6 9 2 9 - 8 3 0 0

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

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 May 28, 1988 at 0645, unplanned ESF actuations occurred when an Equipment Operator (EO) inadvertantly opened the wrong breaker during a tagging operation. The plant was in Operational Condition 4 (Cold Shutdown) with the mode switch in shutdown and all rods inserted in the core. The EO, utilizing an approved SECP (Station Equipment Clearance Permit), was in the Emergency Switchgear Room 102 to open a breaker that supplied power to the Standby Liquid Control heat tracing. However, when it was time to open the breaker, he inadvertantly opened the incorrect breaker which was located below the correct one. This caused a loss of power to the RPS "B" Bus resulting in the initiation of several ESFs. The Control Room notified the EO to halt the tagging operation. Power was subsequently restored to the bus and all systems were returned to normal. Plant Management was notified of the event and the NRC was notified at 0800 per 10CFR50.72. The incident was discussed with all operators and the EO involved was counseled as to the importance of exercising care when de-energizing circuits.

IE22
1/1

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

Energy Industry Identification System (EIIS) codes are identified in the text as [xx].

IDENTIFICATION OF THE EVENT

Loss of RPS Bus "B" due to Equipment Operator error during a tagging operation.

Event Date: 5/28/88

Report Date: 6/24/88

CONDITIONS PRIOR TO THE EVENT

Operational Condition 4 - Cold Shutdown

Mode Switch - Shutdown

RPV Pressure = 0 psig RPV Temperature = 105 Degrees F

POWER LEVEL - 0

All rods inserted in the core.

DESCRIPTION OF THE EVENT

On May 28, 1988 at 0645 unplanned ESF actuations occurred when an Equipment Operator (EO) inadvertantly opened the wrong breaker during a tagging operation.

The EO (#1) was assigned by the Nuclear Station Operator (NSO) to hang a Station Equipment Clearance Permit (SECP) in preparation for a power outage to seven Motor Control Centers located throughout the plant. This was to facilitate inspections for Equipment Qualification purposes. Another EO (#2) was sent to the Reactor Building to hang a tag on a power supply to the Standby Liquid Control (SLC) heat tracing to ensure it remained operable while the redundant heat tracing was removed from service. EO #1 reported to Emergency Switchgear Room 102 to locate the breaker to be opened for the power outage. After identifying the correct breaker (1R24*SWG112-3A) he awaited notification from EO #2 that the tag was hung for the heat tracing. Upon receiving this notification, he then walked over to the panel and opened up breaker 1R24*SWG-112-3C which is located two breakers below the one he should have opened. This action caused a loss of power to RPS "B" and the following systems initiated:

- 1/2 RPS "B"
- 1/2 NS4 isolation
- "B" RBSVS
- "B" CRAC
- RWCU isolation
- RBCLCW "B" split

The Control Room notified the EO of what had just occurred and instructed him to halt the tagging operation. At 0720, power was restored to RPS Bus "B", RWCU was returned to its normal configuration prior to the event and the NS4 isolation signal was cleared. The RBCLCW system was returned to its normal configuration and CRAC was reset at 0730. At 1117, RBSVS was reset and RBNVS was restored. Plant Management was notified of the event and the NRC was notified per 10CR50.73 at 0800.

CAUSE OF THE EVENT

The cause of the event was personnel error for failing to follow plant procedures. The EO was aware of the correct breaker that should have been opened, however he inadvertantly opened the incorrect breaker. The tag in his hand and the SECP he was using identified the correct breaker. The breakers were properly labeled with high visibility labels.

ANALYSIS OF THE EVENT

This event resulted in unplanned automatic actuations of ESF systems (1/2 RPS, 1/2 NS4, RBSVS/CRAC, RWCU and RBCLCW) and is reportable per 10CFR50.73 (a) (2) (iv). There is minimal safety significance to the event. All systems operated as designed. Operators carried out all required actions. Had this event occurred under a more severe set of circumstances (5% power), the safety significance would still be minimal.

CORRECTIVE ACTION

The incident was discussed with all operators. The EO involved was counseled as to the importance of exercising care when de-energizing circuits and the need to be more aware of his actions.

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

ADDITIONAL INFORMATION

a. Manufacturer and model number of failed component (s)

None

b. LER numbers of previous similar events

85-054

LONG ISLAND LIGHTING COMPANY

SHOREHAM NUCLEAR POWER STATION • P.O. BOX 628 • WADING RIVER, NEW YORK 11792

TEL. (516) 929-8300

June 24, 1988

PM-88-170

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Dear Sir:

In accordance with 10CFR50.73, enclosed is Shoreham Nuclear Power Station's Licensee Event Report LER 88-007.

Sincerely yours,

William E. Steiger, Jr.
Plant Manager

DAS/jp

Enclosure

cc: William T. Russell, Regional Administrator
Frank Crescenzo, Resident Inspector
Institute of Nuclear Power Operations, Records Center
American Nuclear Insurers

SR.A21.0200

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