

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Cooper Nuclear Station										DOCKET NUMBER (2) 0 5 0 0 0 2 9 8 1 OF 0 3										PAGE (3) 1 OF 0 3	
TITLE (4) Inadvertent Actuation of #1 Emergency Diesel Generator Overspeed Trip With The Engine In Standby While #2 Emergency Diesel Generator Was Inoperable For Maintenance																					
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 2	1 6	8 9	8 9	0 0 4	0 0 0	0 3	2 0	8 9							0 5 0 0 0						
OPERATING MODE (9) N			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 8: (Check one or more of the following) (11)																		
POWER LEVEL (10) 0 6 1			20.402(b)			20.405(c)			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)			X 50.73(a)(2)(vii)			OTHER (Specify in Abstract below and in Text, NRC Form 386A)									
			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 Ralph W. Krause										TELEPHONE NUMBER 4 0 2 8 2 5 - 3 8 1 1											
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 February 16, 1989, a #1 Emergency Diesel Generator (EDG) trouble alarm was received due to an inadvertent actuation of the Safety Shutdown Valve overspeed trip lever. The condition would have prevented the EDG, which was in standby, from starting in either automatic or manual. At the time of the occurrence, the redundant #2 EDG was out-of-service for maintenance.

The inadvertent actuation of the overspeed trip was caused by utility personnel as-building control air tubing in the vicinity of the Safety Shutdown Valve. The overspeed trip was reset within two minutes of receipt, and the EDG was subsequently started and loaded to demonstrate operability.

To minimize the possibility of recurrence, access to the platform areas on both diesel generators has been administratively restricted. Additionally, a design change will be implemented to provide a permanent guard around the Safety Shutdown Valve overspeed trip lever. The modification will be completed prior to plant startup from the 1989 Maintenance and Refueling Outage.

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CENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

tion	DOCKET NUMBER (2)										LER NUMBER (6)						PAGE (3)				
											YEAR		SEQUENTIAL NUMBER		REVISION NUMBER						
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Additional NRC Form 388A's (17)

Event Description

On February 16, 1989, at 9:10 P.M., a #1 Emergency Diesel Generator (EDG) trouble alarm was received in the Main Control Room. Further investigation at the local control panel revealed annunciators "Failure to Start" and "Overspeed", alarming. The EDG was neither in a starting sequence nor running at the time of the alarms; and the alarming condition was manually reset within two minutes. The alarms were caused when utility personnel as-building control air tubing inadvertently disturbed the Safety Shutdown Valve (SSV), which actuated the overspeed trip lever. During the time interval between the initiation of the alarm condition and reset, the EDG would not have started in either automatic or manual. At the time of the event, the redundant EDG was out-of-service for preventive maintenance.

Plant Status

The plant was operating at 61% of rated power (477 MWe) at the time of the event.

Basis for Report

The event is being reported under 10CFR50.73(a)(2)(vii), where a single occurrence resulted in the Emergency Diesel Generator power supply system being momentarily inoperable.

Cause

Human Factors. Three days prior to the incident, #1 Emergency Diesel Generator had been declared inoperable due to a control air header leak at the SSV (reported via LER 89-003). Corrective action included tubing reconfiguration and replacement in selected areas on both diesel engines. The tubing work had been completed for #1 EDG earlier on February 16 and the tubing upgrade work had just started on #2 EDG. Utility personnel were studying the completed tubing work on #1 EDG and unknowingly actuated the overspeed trip on the SSV. The SSV is mounted in a relatively unprotected area on top of the engine, adjacent to a walkway.

Safety Significance

Minimal. Operations personnel arrived at the #1 EDG Room approximately one minute after receipt of the trouble alarm. The individuals were able to reset the overspeed trip immediately after arriving at the scene. The EDG was in a tripped condition for less than two minutes, during which time automatic or manual operation was prevented. When the alarming condition was reset, the EDG was available for operation if required. Additionally, both offsite power sources were available.

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

A. Event Description

On February 16, 1989, at 9:10 P.M., a #1 Emergency Diesel Generator (EDG) trouble alarm was received in the Main Control Room. Further investigation at the local control panel revealed annunciators "Failure to Start" and "Overspeed", alarming. The EDG was neither in a starting sequence nor running at the time of the alarms; and the alarming condition was manually reset within two minutes. The alarms were caused when utility personnel as-building control air tubing inadvertently disturbed the Safety Shutdown Valve (SSV), which actuated the overspeed trip lever. During the time interval between the initiation of the alarm condition and reset, the EDG would not have started in either automatic or manual. At the time of the event, the redundant EDG was out-of-service for preventive maintenance.

B. Plant Status

The plant was operating at 61% of rated power (477 MWe) at the time of the event.

C. Basis for Report

The event is being reported under 10CFR50.73(a)(2)(vii), where a single occurrence resulted in the Emergency Diesel Generator power supply system being momentarily inoperable.

D. Cause

Human Factors. Three days prior to the incident, #1 Emergency Diesel Generator had been declared inoperable due to a control air header leak at the SSV (reported via LER 89-003). Corrective action included tubing reconfiguration and replacement in selected areas on both diesel engines. The tubing work had been completed for #1 EDG earlier on February 16 and the tubing upgrade work had just started on #2 EDG. Utility personnel were studying the completed tubing work on #1 EDG and unknowingly actuated the overspeed trip on the SSV. The SSV is mounted in a relatively unprotected area on top of the engine, adjacent to a walkway.

E. Safety Significance

Minimal. Operations personnel arrived at the #1 EDG Room approximately one minute after receipt of the trouble alarm. The individuals were able to reset the overspeed trip immediately after arriving at the scene. The EDG was in a tripped condition for less than two minutes, during which time automatic or manual operation was prevented. When the alarming condition was reset, the EDG was available for operation if required. Additionally, both offsite power sources were available.

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

F. Safety Implications

As previously discussed, the unavailability of both EDGs was less than two minutes. The likelihood of an event occurring, which would require Emergency Diesel Generator operation during that two minute period, is extremely small.

G. Corrective Action

Immediately upon receipt of the trouble alarms, an operator was dispatched to the #1 EDG Room. The EDG was reset, and subsequently started and loaded to demonstrate operability.

To minimize the possibility of an inadvertent actuation of the SSV, signs have been placed on the ladders to the platform areas on both diesel engines. Access is restricted to Operations and Maintenance personnel with specific job assignments in the area, or personnel receiving prior permission from the Shift Supervisor. Additionally, a design change will be implemented to provide a permanent guard around the Safety Shutdown Valve overspeed trip lever. The modification will be completed prior to the plant startup from the 1989 Maintenance and Refueling Outage.

H. Past Similar Events

A similar event occurred on November 3, 1988, when non-utility personnel were touring the Emergency Diesel Generator Room and inadvertently actuated the overspeed trip lever. The responsible supervisor counselled the individual involved. The event was not considered reportable because the redundant EDG was operable.