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Edison

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10CFR50.73



Nuclear
Operations

May 29, 1991
NRC-91-0070

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

Reference: Fermi 2
NRC Docket No. 50-341
NRC License No. NPF-43

Subject: Licensee Event Report (LER) No. 91-009

Please find enclosed LER No. 91-009, dated May 29, 1991, for a reportable event that occurred on April 29, 1991. A copy of this LER is also being sent to the Regional Administrator, USNRC Region III.

If you have any questions, please contact Joseph Pendergast, Compliance Engineer, at (313) 586-1682.

Sincerely,

Enclosure: NRC Forms 366, 366A

cc: A. B. Davis
J. R. Eckert
R. W. DeFayette
W. G. Rogers
J. F. Stang

Wayne County Emergency
Management Division

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PDR ADOCK 05000341
S PDR

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Fermi 2										DOCKET NUMBER (2) 0 5 0 0 0 3 4 1										PAGE (3) 1 OF 0 4									
TITLE (4) Loss of Power to Bus 65F Causes Engineered Safety Feature Actuations																													
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	4	2	9	9	1	9	1	0	0	9	0	0	0	5	2	9	9	1	0	5	0	0	0						
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)																											
POWER LEVEL (10)		20.402(b)		20.406(c)		X		50.73(a)(2)(ix)		73.71(b)																			
		20.406(e)(1)(i)		50.38(c)(1)				50.73(a)(2)(x)		73.71(c)																			
		20.406(e)(1)(ii)		50.38(c)(2)				50.73(a)(2)(xi)		OTHER (Specify in Abstract below and in Text NRC Form 306A)																			
		20.406(e)(1)(iii)		50.73(a)(2)(ii)				50.73(a)(2)(vii)(A)																					
		20.406(e)(1)(iv)		50.73(a)(2)(iii)				50.73(a)(2)(vii)(B)																					
		20.406(e)(1)(v)		50.73(a)(2)(iv)				50.73(a)(2)(x)																					
LICENSEE CONTACT FOR THIS LER (12)																													
NAME										TELEPHONE NUMBER																			
Joseph Pendergast, Compliance Engineer										3 1 3 5 8 6 - 1 6 8 2																			
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																													
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC																				
SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH		DAY		YEAR													
Y/N "If yes, col. 15c EXPECTED SUBMISSION DATE"										X NO																			

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On April 29, 1991, surveillance test 42.302.06, "Calibration and Logic System Functional Test of Division II 4160 Volt Emergency Bus 65F and 14ED Undervoltage Circuits", was in progress. At 0910 hours, power was lost to bus 65F and its associated buses 72F, 14ED, and 72ED. Division I of the Reactor Building Heating Ventilation and Air Conditioning (RBHVAC) system isolated and Standby Gas Treatment System (SGTS) automatically started. The Control Center Heating Ventilation and Air Conditioning System (CCHVAC) received an isolation signal. However, it was already in the recirculation mode for other surveillance testing.

Initial investigation determined that, due to personnel error, knife switch 65F-F6 was not in the correct position prior to performing step 5.2.5.10.a of 42.302.06. Subsequently, the knife switch was correctly positioned. RBHVAC and SGTS were returned to normal at 1052 hours. An accountability meeting was held for this event. The event was discussed in detail and corrective actions were determined.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		1	0 0 9	0 0	0 2	OF 0 4

TEXT (If more space is required, use additional NRC Form 386A's) (17)

Initial Plant Conditions:

Operational Condition: Defueled
Reactor Power: 0 Percent
Reactor Pressure: 0 psig
Reactor Temperature: 95 degrees Fahrenheit

Description of Event:

On April 29, 1991, surveillance test 42.302.06, "Calibration and Logic System Functional Test of Division II 4160 Volt Emergency Bus (BU) 65F and 14ED Undervoltage Circuits", was in progress. At 0910 hours, power was lost to bus 65F and its associated buses 72F, 14ED, and 72ED. The following equipment was affected: a half scram signal was initiated on the Reactor Protection System (JC), the center Reactor Building Closed Cooling Water (CC) pump (P) tripped, Area Radiation Monitors (ARM) (MON) for the refueling floor become inoperable and the diesel fire pump (KP) automatically started. The Division I of the Reactor Building Heating, Ventilation and Air Conditioning (RBHVAC) (VI) system isolated and Standby Gas Treatment System (SGTS) (BH) automatically started. The Control Center Heating, Ventilation and Air Conditioning System (CCHVAC) (VI) received an isolation signal. However, CCHVAC was already in the recirculation mode for other surveillance testing.

Initial investigation determined that knife switch 65F-F6, trip cut-off switch for the bus load shedding circuit, was not in the correct position prior to performing step 5.2.5.10.a of 42.302.06. This switch is a 94 cut off switch located at switch gear position 65-F6. Subsequently, the knife switch was correctly positioned. RBHVAC and SGTS were returned to normal status at 1052 hours. System restoration from loss of the 65F bus was completed at 1115 hours.

Cause of Event:

The loss of power to bus 65F, occurred while performing surveillance test 42.302.06 at step 5.2.5.10.a due to a mispositioned knife switch. The surveillance was worked April 27 through April 29. The knife switch 65F-F6 was open (per procedural sign-off) when the surveillance was stopped for the day on April 28. The knife switch was repositioned between the time when the surveillance was stopped on April 28 and when the surveillance was restarted on April 29.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-630), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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

The root cause of this event was personnel error. Knife switch 65F-F6 had been inadvertently placed in the closed position and had not been reverified open, as required by NPP-CT1-01, "Surveillance/Performance Package Control", prior to performing step 5.2.5.10.a of procedure 42.302.06. The knife switch should have been in the open position for performance of the surveillance test. It has not been determined who placed the knife switch in the wrong position. The following factors contributed to this event:

- o Tags were not installed on the plant components that were placed in an abnormal position for the test.
- o Previously the surveillance was normally performed on a continuous basis until complete. This test was performed over a 3 day period.

Analysis of Event:

The RBHVAC, CCHVAC and SGTS Engineered Safety Feature responses were consistent with the design basis of these systems. Thus, this event did not decrease the ability of these systems to perform their safety design functions. Additionally, this surveillance is only performed during plant outages. As a result, this event had no impact on plant safety. Therefore, the health and safety of the public and plant employees was protected.

Corrective Actions:

An accountability meeting was held for this event. The accountability meeting was attended by the the individuals involved, their supervisor, security, plant safety and the plant manager as the chairman. Reverification of surveillance procedure steps was discussed during the meeting. In addition, plant security has interviewed personnel. It could not be determined through the security interviews or accountability meeting how the switch was closed. The personnel involved in this event were appropriately counselled by management. The event was discussed in detail at the accountability meeting and corrective actions were determined, as follows:

- o Revise 42.302.06 to require tags to be placed on plant components placed in an abnormal position if the surveillance is stopped for an extended period of time.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555 AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Fermi 2	DOCKET NUMBER (2) 0 5 0 0 0 3 4 1	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		9 1	0 0 9	0 0	4	OF 0 4

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

- o Revise 42.302.06 to caution test personnel to reverify test conditions prior to restarting the surveillance if the surveillance was stopped.

Procedure 42.302.06 and other similar electrical surveillance procedures will be revised as needed no later than the end of September 1991.

Previous Similar Events:

Licensee Event Report 89-039, "Partial Load Shedding of Bus 72E Actuated Emergency Equipment Cooling Water and Emergency Equipment Service Water Due To Personnel Error" described a similar event, however, personnel who made the error were identified.