

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)
Salem Generating Station - Unit 1DOCKET NUMBER (2)
0 5 0 0 0 2 7 2 1 OF 0 4TITLE (4)
Loss of all 4KV Group and Vital Busses - Units 1 and 2

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	6	0	2	8	4	8	4	0	1	3	0	0	0	7	0	2	8	4	Salem - Unit 2	0	5	0	0	0	3	1	1
											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)													
6		20.402(b)		20.408(c)		50.73(a)(2)(iv)		73.71(b)							
POWER LEVEL (10)	0 10 0	20.408(a)(1)(i)		50.38(a)(1)	X	50.73(a)(2)(v)		73.71(a)							
		20.408(a)(1)(ii)		50.38(a)(2)		50.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 365A)							
		20.408(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(vii)(A)									
		20.408(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(vii)(B)									
		20.408(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(ix)									

LICENSEE CONTACT FOR THIS LER (12)
NAME
J. L. RuppTELEPHONE NUMBER
AREA CODE
6 0 9 3 3 9 - 4 3 0 9

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)
YES (If yes, complete EXPECTED SUBMISSION DATE) ☒ NO ☐EXPECTED SUBMISSION DATE (15)
MONTH DAY YEAR

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

On June 2, 1984, power was interrupted between the 500 KV yard and the 13KV bus, resulting in a loss of on-site power to the Unit 1 and Unit 2 4KV Group and Vital Busses. Unit 1 was in a refueling outage at the time with the reactor defueled, and Unit 2 was in Cold Shutdown. Unit 2 Emergency Diesels started and loaded in the Blackout Mode; Unit 1 Emergency Diesels and 1B Vital Bus were cleared and tagged for maintenance. Unit 2 RHR pumps were removed from service by the SEC sequencer, resulting in a loss of Residual Heat Removal flow. Power was restored to all Group Busses within thirty seconds. Control of vital bus loads was regained, and RHR was immediately restored. Unit 2 Vital Busses were then transferred to station power and the diesels were secured. The event was the result of a Nuclear Control Operator opening the wrong 500KV Circuit Switchgear. This was due to not fully understanding the switchgear controls that were available to him, and not reading the label on the console control prior to its operation. This event was aggravated by relaying the order to Unit 2 Control Room via the Unit 1 Control Room NCO. The individual involved was counseled and reprimanded for his actions associated with the event. Two newsletter items discussed the incident and causes. Due to the loss of RHR, this event is reportable in accordance with 10CFR 50.73(a)(2)(v)(B).

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PLANT AND SYSTEM IDENTIFICATION:

Westinghouse - Pressurized Water Reactor

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

IDENTIFICATION OF OCCURRENCE:

Loss of All 4KV Group And Vital Busses - Units 1 and 2

Event Date: 06/02/84

Report Date: 07/02/84

This report was initiated by Incident Report No. 84-086

CONDITIONS PRIOR TO OCCURRENCE:

Unit 1 - Mode 6 - Rx Power 000% - Unit Load 0000 MWe - (Defueled)

Unit 2 - Mode 5 - Rx Power 000% - Unit Load 0000 MWe

DESCRIPTION OF OCCURRENCE:

On June 2, 1984, in preparation for a 13KV Bus Section 4 outage, all station power was transferred to No. 1 Station Power Transformer. The Shift Supervisor (SS) and the Equipment Operator (EO) went to the 500KV yard to clear and tag the 13KV Bus Section 3-4 and 4-5 breakers. After racking out the 13KV breakers, it was found that there were no tags for the breaker control power deions. The SS instructed the EO to call Unit 1 Control Room and have them generate tags for the control power breakers (the original tagging request had been generated in Unit 1 Control Room), and to inform Unit 2 Control Room to open 2T60 500KV Circuit Switchgear. The EO called Unit 1 Control Room, spoke with the Unit 1 Nuclear Control Operator (NCO) and requested the tags for the control power breakers. He then requested that 2T60 500KV Circuit Switchgear be opened from the Unit 2 Control Room. At 0354 hours, following the discussion with the EO, the Unit 1 NCO proceeded to the Unit 1 control console and opened 1T60. This interrupted the power between the 500KV yard and the 13KV bus, which caused a loss of on-site power to the Unit 1 and Unit 2 4KV Group and Vital Busses [EB]. Technical Specification Action Statement 3.8.1.2.a was entered due to the loss of power from the 500KV yard, and Action Statement 3.4.1.4.b was entered due to the loss of the RHR pumps.

A blackout signal was sensed by the Safeguard Equipment Cabinets (SEC's) on both units. Unit 2 Emergency Diesels started and loaded in the Blackout Mode. The Unit 1 Emergency Diesels and 1B Vital Bus were cleared and tagged for a maintenance outage.

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DESCRIPTION OF OCCURRENCE: (cont'd)

As a result of the Blackout Mode of operation, the Unit 2 RHR [BP] pumps were removed from service by the SEC sequencer. After approximately thirty (30) seconds, realizing he had opened the wrong switchgear, the NCO reclosed 1T60, restoring power to all 4KV Group Busses. The Safeguard Loading was then reset to regain control of equipment on 2A, 2B and 2C Vital Busses. RHR was restored to service and the Unit 2 Vital Busses were transferred to station power. The diesels were then secured, and Technical Specification Action Statements 3.8.1.2.a and 3.4.1.4.b were terminated. The Nuclear Regulatory Commission was notified of the event IAW the Code of Federal Regulations 10CFR 50.72(b)(2)(iii)(B), non-emergency event, four hour report.

APPARENT CAUSE OF OCCURRENCE:

The cause of the event was attributed to the Unit 1 NCO not following the instructions which he was given; specifically, to have Unit 2 Control Room open 2T60. Although Unit 1 Control Room has indication of 2T60 on the mimic bus, it contains only the controls for 1T60. The NCO, not fully understanding this, looked at the 2T60 indication, failed to read the label on the console control and opened 1T60. Issuing the order to Unit 2 Control Room via Unit 1 Control Room contributed to the occurrence.

ANALYSIS OF OCCURRENCE:

Technical Specification Action Statement 3.8.1.2.a states:

With less than one circuit between the off-site transmission network and the on-site Class 1E distribution system, suspend all operations involving core alterations or positive reactivity changes until the circuit is restored to an operable status.

Technical Specification Action Statement 3.4.1.4.b states:

With no RHR loop in operation, suspend all operations involving a reduction in boron concentration of the Reactor Coolant System and immediately initiate corrective action to return the required RHR loop to operation.

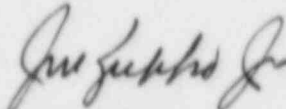
As previously stated, power was immediately restored and RHR was returned to service in a timely fashion. Unit 2 SEC and Emergency Diesels responded as required to the loss of off-site power, and operations were in accordance with the appropriate Technical Specification action requirements. This event involved no undue risk to the health or safety of the public. Because this event involved the loss of RHR and the ability to remove residual heat, the occurrence is reportable in accordance with the Code of Federal Regulations, 10CFR 50.73(a)(2)(v)(B).

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CORRECTIVE ACTION:

The NCO involved was counseled and received a written reprimand concerning his actions associated with this event. He was advised that when conducting operations such as this, that he must fully understand the evolution and consult the procedures or shift supervision as necessary. He was advised that he must read the labels on controls prior to its operation. He was also directed to consult shift supervision prior to attempting a recovery from any situation such as this. In addition, this event was discussed in the Operations Newsletter. A second newsletter item addressed the problem with relaying orders, rather than discussing the evolution directly with the person involved.



General Manager-
Salem Operations

JLR:tns

SORC Mtg 84-078B



PSEG

Public Service Electric and Gas Company P.O. Box E Hancocks Bridge, New Jersey 08038

Salem Generating Station

July 2, 1984

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

Dear Sir:

SALEM GENERATING STATION
LICENSE NO. DPR-70
DOCKET NO. 50-272
UNIT NO. 1
LICENSEE EVENT REPORT 84-013-00

This Licensee Event Report is being submitted pursuant to the requirements of 10CFR 50.73(a)(2)(v)(B). This report is required within thirty (30) days of discovery.

Sincerely yours,

J. M. Zupko, Jr.
General Manager -
Salem Operations

JR:kl1

CC: Distribution

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