WOLF CREEK
NUCLEAR OPERATING CORPORATION

John A. Bailey
Vice President
Operations

July 2, 1992

NO 92-0190

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D. C. 20555

Subject: Docket No. 50-482: Licensee Event Report 91-023-01

Gentlemen:

The attached Licensee Event Report (LER) is a supplement to LER 91-023-00 which was submitted pursuant to 10 CFR 50.73 (a)(2)(iv) concerning an Engineered Safety Features Actuation.

Very truly yours,

John A. Bailey

John A. Bailey
Vice President
Operations

JAB/aem

Attachment

cc: A. T. Howell (NRC), w/a
J. L. Milhoan (NRC), w/a
G. A. Pick (NRC), w/a
W. D. Reckley (NRC), w/a

IE22

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1): Wolf Creek Generating Station

DOCKET NUMBER (2): 0 5 0 0 0 4 8 2 | PAGE (3): 1 OF 0 4

TITLE (4): Accidental Bumping of 120 Volt Supply Panel Results in Engineered Safety Features Equipment Actuations

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	DOCKET NUMBER (5)
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR		
1 1	1 9	9 1	9 1 -	0 2 3 -	0 1	0 7	0 2	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): 5

POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR: (Check one or more of the following) (11)

20.402(b)	20.405(c)	X 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)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
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: Steve G. Wideman - Supervisor Licensing

TELEPHONE NUMBER: AREA CODE 3 1 6 3 6 4 - 8 8 3 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)

[ ] YES (If yes, complete EXPECTED SUBMISSION DATE) [X] NO

EXPECTED SUBMISSION DATE (15): MONTH | DAY | YEAR

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

On November 19, 1991, at 2106 CST, 480 Volt Supply Breaker 52NG02BAF4 tripped, resulting in a loss of power to various radiation monitors. This loss of power initiated a Control Room Ventilation Isolation Signal, a Fuel Building Isolation Signal, and a Containment Purge Isolation Signal.

The root cause of this event has been attributed to inadvertent bumping of the operating switch to breaker 52NG02BAF4 by non-licensed personnel. Exercising caution while working near plant equipment has been re-emphasized with the responsible work group and the remaining groups in the department. Additionally, the operating switch has been inspected and it was determined that a hardware problem did not contribute to the breaker tripping.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Wolf Creek Generating Station	0 5 0 0 0 4 8 2	9 1	- 0 2 3	- 0 1	0 2 OF 0 4

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

INTRODUCTION

On November 19, 1991, at 2106 CST, 480 Volt Supply Breaker 52NG02BAF4 tripped, resulting in a loss of power to various radiation monitors. This loss of power initiated a Control Room Ventilation [VI] Isolation Signal (CRVIS), a Fuel Building [VG] Isolation Signal (FBIS), and a Containment Purge [VA] Isolation Signal (CPIS). This event is being reported pursuant to 10 CFR 50.73(a)(2)(iv) as an unplanned Engineered Safety Features (ESF) actuation.

DESCRIPTION OF EVENTS

On November 19, 1991, at 2106 CST, with the plant in Mode 5, Cold Shutdown, a CRVIS, FBIS and CPIS were received. Investigation into the cause of the isolation signals revealed that they were caused by a trip of 480 Volt Supply Breaker 52NG02BAF4 [ED-BKR]. This breaker supplies Distribution Transformer XNG02B which in turn supplies 120 Volt Distribution Panel NG02B [ED-PL]. The breaker trip caused Containment Atmosphere Radiation Monitor GT RE-031 [IL-MON], Containment Purge Padiation Monitor GT RE-033 [IL-MON], Control Room Air Intake Radiation Monitor GK RE-004 [IL-MON] and Fuel Building Exhaust Radiation Monitor GG RE-078 [IL-MON] to lose communication. All required ESF equipment responded properly.

When the Auxiliary Building Watch arrived to investigate the cause of the isolation signals, he found Maintenance and Modification personnel performing maintenance in the vicinity. An individual stated he had heard a click as he passed the cubicle that houses the breaker operating switch. After further discussion it was concluded that the individual may have inadvertently bumped the switch, thereby tripping the breaker.

At 2157 CST, the breakers on the 120 volt bus were opened and breaker 52NG02BAF4 was reset. After satisfactorily resetting breaker 52NG02BAF4, the remaining 120 volt breakers were re-energized one at a time. All loads energized successfully. The tripped radiation monitors and the CPIS and FBIS were reset at approximately 2240 CST. Upon completion of local actions and preliminary investigation, the Auxiliary Building Watch notified the Control Room at 2300 CST that Maintenance and Modifications personnel were working in the vicinity and that it appeared that the breaker trip resulted from an individual inadvertently bumping the operating switch to breaker 52NG02BAF4. The CRVIS was restored at 0107 CST on November 20 following repairs for an unrelated work request.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Wolf Creek Generating Station	0 5 0 0 0 4 8 2	9 1	- 0 2 3	- 0 1	0 3 OF 0 4

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

ROOT CAUSE AND CORRECTIVE ACTION

The root cause of this event has been attributed to inadvertent bumping of the operating switch to breaker 52NG02BAF4 by non-licensed personnel. Exercising caution while working near plant equipment has been re-emphasized with the responsible work group and the remaining groups in the department. Additionally, the operating switch was inspected and it was determined that a hardware problem did not contribute to the breaker tripping.

ADDITIONAL INFORMATION

Licensee Event Reports 85-026-00, 85-051-00, 88-029-00, and 90-001-00 describe events where ESF actuations resulted from personnel inadvertently bumping a component or cubicle while performing activities unrelated to the affected equipment. Personnel were briefed after these events on the importance of exercising caution while working in the vicinity of plant equipment and the need to contact the Control Room promptly any time plant equipment may have been bumped. The personnel involved, after hearing the click, did not recognize the possibility that the switch may have been bumped and therefore did not identify the necessity to contact the Control Room. However, when the Auxiliary Building Watch arrived to investigate the cause of the isolation signals, they made him aware of the click they had heard and discussed the possibility that the cubicle may have been bumped.

Licensee Event Reports 86-044-00, 87-041-00, and 89-004-00 also describe events where ESF actuations resulted from personnel inadvertently bumping a component or cubicle. However, these events are not considered similar to the event described in this report because the activities being performed were directly related to the affected equipment (see Table I).

There was no danger to plant equipment or release of radioactivity as a result of this event. Because this event placed the affected ESF systems in their safeguards line-up, there was no threat to the health or safety of the public.

Identifier	Date	Conditions	Cause	Discussion
Events considered similar				
LER 85-026	5/6/85	Mode 3	Bumped cubicle door while cleaning.	Cubicle door was inadvertently struck during cleaning activities in general vicinity of cabinet. Resulted in tripping of feeder breaker 152NB0110 to 480 volt NG03 on undervoltage. (CPIS, FBIS, CRVIS) Briefings to personnel.
LER 85-051	7/20/85	67%	Bumped start relay.	Instrumentation and Controls technician inadvertently bumped start relay to EDG 'A', causing it to start . Caution stressed to all I&C technicians.
LER 88-029	12/28/88	Mode 4	Bumped local main power switch.	Insulation worker bumped local main power switch causing failure of GT RE-032 (CPIS, CRVIS) He did attempt to call Control Room, line was busy. He went ahead and reset switch. Met operator when leaving area. Corrective actions included discussion with crew about contacting Control Room and not resetting.
LER 90-001	2/6/90	100%	High diff. current.	Reactor Coolant Pump 'A' trip. High differential current on phase 'A'. Event believed to be result of inadvertent bumping.
Events not considered similar				
LER 86-044	9/2/86	10%	Jarred panel door when closing.	Utility personnel in switchyard may have jarred the panel door when closing it, thereby causing relay 94 EDF to trip. (Partial loss of offsite power) Activities which required opening this door were cancelled and performed by other means.
LER 87-[illegible]	9/27/87	86% Reducing for Refuel II	Bumped switch while cleaning rod control cabinets.	Contractor personnel inadvertently bumped a switch while cleaning top of rod control cabinets which resulted in de-energizing the movable gripper coil for Bank 'D', Group 'A' control rods. Individual did promptly contacted Control Room. Operator arrived to investigate. No ind. ation (alarms, etc.) of the loss of power. Thought everything was okay. Later tried to move control rods, they dropped. Root cause focused on operator error when investigating problem.
LER 89-004	2/2/89	100%	Loose screw on terminal strip.	I&C technician may have bumped plastic cable raceways when performing other maintenance. Resulted in fast close signal to MSIV 'C'. Further investigation revealed a loose screw on a terminal strip in the ESFS. No actions regarding bumping, root cause attributed to loose screw.

Table I: LICENSEE EVENT REPORTS (LER) RESULTING FROM INADVERTENT BUMPING