Union Electric
Callaway Plant

PO Box 620
Fulton, MO 65251

October 31, 2000

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Mail Stop P1-137
Washington, DC 20555-0001

ULNRC-4334

Gentlemen:

DOCKET NUMBER 50-483
CALLAWAY PLANT UNIT 1
UNION ELECTRIC CO.
FACILITY OPERATING LICENSE NPF-30
LICENSEE EVENT REPORT 2000-007-00
Unplanned Emergency Diesel Generator Actuation Resulting From Inadvertent Actuation of the Local Emergency Start Device

The enclosed licensee event report is submitted in accordance with 10CFR50.73(a)(2)(iv) to report an event that resulted in the manual actuation of an Engineered Safety Feature.

W. A. Witt

W. A. Witt
Manager, Callaway Plant

WAW/mdhu

Enclosure

IE22

cc: Mr. Ellis W. Merschoff
Regional Administrator
U.S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, TX 76011-8064

Senior Resident Inspector
Callaway Resident Office
U.S. Nuclear Regulatory Commission
8201 NRC Road
Steedman, MO 65077

Mr. Jack N. Donohew (2 copies)
Licensing Project Manager, Callaway Plant
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Mail Stop 7E1
Washington, DC 20555-2738

Manager, Electric Department
Missouri Public Service Commission
PO Box 360
Jefferson City, MO 65102

Mr. Thomas A. Baxter
Shaw, Pittman, Potts & Trowbridge
2300 N. Street N.W.
Washington, DC 20037

Records Center
Institute of Nuclear Power Operations
700 Galleria Parkway
Atlanta, GA 30339

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Callaway Plant Unit 1	0 5 0 0 0 4 8 3	1 OF 0 3

TITLE (4) **Unplanned Emergency Diesel Generator Actuation Resulting from Inadvertent Actuation of the Local Emergency Start Device**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	Rev No.	MONTH	DAY	YEAR
1 0	0 3	2 0 0 0	2 0 0 0	- 0 0 7	- 0 0	1 0	3 0	2 0 0 0

OTHER FACILITIES INVOLVED (8)

FACILITY NAMES	DOCKET NUMBER(S)
	0 5 0 0 0
	0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR : (*Check one or more of the following*) (11)			
POWER LEVEL (10) 1 0 0		20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	X 50.73(a)(2)(iv)	OTHER *(Specify in Abstract below or in Text, NRC Form 366A)*
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (AREA CODE)
J. D. Schnack, Supervising Engineer, QA Corrective Action	5 7 3 6 7 6 - 4 3 1 9

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO EPIX

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)

At 2055 on October 3, 2000, an unplanned actuation of the A Train Emergency Diesel Generator (EDG) occurred following an inadvertent actuation of the local emergency start controls by a non-licensed Assistant Equipment Operator (AEO). This actuation occurred during an informational walkdown while the AEO was reviewing procedures associated with locally starting this EDG. Upon locating the local emergency start device, the AEO contacted the glass cover on this device with his index finger. Due to the thickness of this cover, and the relative movement of the glass cover within this device, the glass cover broke resulting in the actuation of the EDG. The EDG subsequently achieved rated speed and voltage, however, no electrical loads were transferred to the EDG since the offsite power supply was not affected.

The human performance error precursor of "Inaccurate Risk Perception" was determined to be applicable in explaining the actions taken by the AEO during this event. This was based on an unrecognized risk associated with the design of the emergency start device which allowed the glass cover to be broken without excessive force. As a result, operating experience training will be provided to Operations personnel regarding this specific event, and the generic implications of this event to other plant systems/components.

DESCRIPTION OF EVENT:

At 2055 on October 3, 2000, an unplanned actuation of the A Train Emergency Diesel Generator (EDG) occurred following an inadvertent actuation of the local emergency start controls by a non-licensed Assistant Equipment Operator (AEO).

At approximately 2055, a non-licensed AEO was performing an informational walkdown of the A Train EDG while reviewing the procedure associated with locally starting this EDG. This procedure contained guidance for performing an emergency local start by breaking a glass cover on an emergency start device mounted on the local control panel. The operating mechanism for this device (SquareD, Class 9001, Type K15 Emergency Break Glass Operator) is normally maintained depressed by a glass cover. A hammer mounted next to the device is utilized to break the glass cover in order to actuate this operating mechanism. Although this glass cover offers some physical protection against inadvertent actuation, the thickness of this cover is only approximately 1/32 of an inch. Additionally, this cover is not secured within this unit and is subject to movement within the device when a force is exerted on the glass cover.

Upon observing this emergency start device, the AEO contacted the glass cover with his index finger. Due to the thickness of this cover, and the relative movement of the glass cover within the device, the glass cover broke resulting in the actuation of this device. The A Train EDG subsequently started and achieved rated speed and voltage. Since the offsite power supply to the associated Class 1E distribution system was not affected, no electrical loads were transferred to the EDG during this event. Following replacement of the glass cover, the EDG was secured and restored to a standby status at 2247.

BASIS FOR REPORTABILITY:

This event is reportable per 10CFR50.73(a)(2)(iv) as an event or condition that resulted in the manual actuation of an Engineered Safety Feature (ESF).

CONDITION AT TIME OF EVENT:

Mode 1, 100% power

ROOT CAUSE:

The human performance error precursor of "Inaccurate Risk Perception" was determined to be applicable in explaining the actions taken by the AEO during this event. This was based on an unrecognized risk associated with the design of the emergency start button which allowed the glass cover to be broken without excessive force.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REV NO.	
Callaway Plant Unit 1	0 5 0 0 0 4 8 3	2 0 0 0	- 0 0 7	- 0 0	0 3 OF 0 3

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

CORRECTIVE ACTIONS:

Operating experience training will be provided to Operations personnel regarding this specific event, and the generic implications of this event to other plant systems/components.

SAFETY SIGNIFICANCE:

This event was not considered to be risk significant since this actuation did not impact the ability of any safety systems to perform their design basis function during this event. Had the offsite power source to this distribution system been lost, the A Train EDG remained capable of accepting the design basis loading of this distribution system throughout the duration of this event.

PREVIOUS OCCURRENCES:

No previous occurrences were identified of inadvertent EDG actuations that had resulted from the actuation of this emergency start device.

FOOTNOTES:

The system code listed below is taken from IEEE Standard 805-1984.

System EK