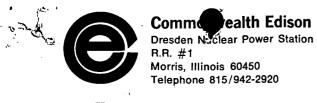
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July 14, 1978

BBS Ltr. #78-1030

James G. Keppler, Regional Director Directorate of Regulatory Operations - Region III U.S. Nuclear Regulatory Commission 799 Roosevelt Road Glen Ellyn, IL 60137

ealth Edison

Reportable Occurrence Report #77-059/01X-1, Docket #050-249 is hereby submitted to your office to supplement Licensee Event Report. 77-059/01T-0 concerning the Unit 3 Diesel Generator Feed Breaker to Bus 34-1 pulled tollock. It addresses the corrective actions implemented to prevent a recurrence. This event was reported to you under Dresden Nuclear Power Station Technical Specification 6.6.B.1.(f), personnel error or procedural inadequacy which prevents or could prevent, by itself, the fulfillment of the functional requirements of systems required to cope with accidents analyzed in the SAR.

. R Stephenson

Superintendent Dresden Nuclear Power Station

BBS/kmh

Enclosure

Director of Inspection & Enforcement CC: Director of Management Information & Program Control File/NRC

JUL 1 8 1978

NRC FORM 366 W. S. NUCLEAR REGULATURY COMMISSION (7-77) . LICENSEE EVENT REPORT CONTROL BLOCK:](ı) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) 0 0 0 0 0 0 - 0 0 3 4 1 LICENSE NUMBER S 0 D R <u>3 (2)</u> 1 LICENSEE CODE CON'T 605002497122877786REPORT 0 1 SOURCE 7 1 பகில DOCKET NUMBER EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) While Unit 3 was at steady-state operation, 2/3 diesel was taken out of service for 0 2 However, the operator mistakenly pulled the U3 D/G to Bus 34-1 switch to inspection. 03 lock and placed the out-of-service card there, thus making the U3 D/G inoperable in 0 4 that the feedbreaker would not close in case of loss of offsite power. 0 5 The mistake 0 6 was discovered and corrected in three hours and in this period offsite power was This is not a repetitive event 0 7 available. 0 8 RD SYSTEM CODE CAUSE CAUSE COMP. VALVE SUBCODE COMPONENT CODE CODE SUBCODE SUBCODE Εİ E 9 A (12) A | (13) İΖ ΙZ (14 Zŀ (16)13 18 19 20 REVISION SEQUENTIAL OCCURRENCE REPORT LER/RO EVENT YEAR REPORT NO. CODE TYPE NO. (17) REPORT 0 5 9 0 1 X 1 NUMBER 26 28 - 31 32 . 29 ATTACHMENT SUBMITTED ACTION FUTURE TAKEN ACTION EFFECT ON PLANT SHUTDOWN NPRD-4 PRIME COMP. COMPONENT HOURS (22) METHOD FORM SUB. SUPPLIER MANUFACTURER ¥ 23 -Z_(20) 0 0 0 <u>H</u> (18) H (19) Z (21) 01 N Z (25) Z | 9 | 9 9 ____(24) (26) 36 35 47 CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) Mistake was promptly corrected and operator was instructed of the error. Operating 10 personnel have been made aware of the importance of avoiding operating erro 1 1 Shift starting times have been moved up ½ hr. In addition, the station will continue the policy of independently verifying all safety related equipment outages 3 4 9 8 80 FACILITY METHOD OF DISCOVERY (30) OTHER STATUS DISCOVERY DESCRIPTION (32) % POWER 5 E (28) 0 7 0 (29) A (31) NA NRC Personnel Inspection 8 10 13 44 80 9 46 CONTENT ACTIVITY AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36) OF RELEASE RELEASED Ζ (33) Z (34) 6 NA NA 10 45 80 PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER TYPE 0 (37) (38 - 7. NA 80 PERSONNEL INJURIES DESCRIPTION (41) NUMBER 8 0 (40) ۱٥ 0 NA 9 11 12 80 LOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION 9 (42) NA 10 PUBLICITY NRC USE ONLY DESCRIPTION (45) ISSUED <u>N</u> (44 0 NA 10 68 69 80 J. Chan 040 NAME OF PREPARER. 222 PHONE:

ATTACHMENT TO LICENSEE EVENT REPORT 77-059/01X-1 COMMONWEALTH EDISON COMPANY (CWE) DRESDEN UNIT 3 (ILDRS-3) DOCKET # 050-249

At 0545 on December 28, 1977, while Unit 3 was at steady-state operation, the Unit 2/3 diesel generator was taken out of service for a monthly maintenance inspection. The diesel was taken out of service locally, and the 2/3 D/G to Bus 33-1 feed breaker was racked out. However, the operator in the Control Room mistakenly put the out-of-service card on the 3 D/G to Bus 34-1 breaker switch and placed that switch in the pull to lock position. In doing this the 3 D/G was made inoperable because in the event of a loss of offsite power, the diesel would not auto close to Bus 34-1. The mistake was discovered at 0850 on the same date and was immediately corrected. In the 3-hour period Unit 3 diesel generator was inoperable, off-site power was available. In addition, the Unit 3 diesel could have been returned to operation by placing the breaker control switch (to Bus 34-1) to the normal position had offsite power been lost, because the feed breaker was not racked out. This is not a repetitive event.

Immediately after discovery of the mistake, proper corrective action was taken. The operator was instructed of the error. All diesel generator switches in the control room have been color coded to identify different diesel generators. Through the company Professionalism Program, the Station has made operating personnel aware of the importance of avoiding operating errors. Shift starting times have been moved up ½hour to enable the control room operators to conduct a more thorough operational walk down of their control boards before the peak periods of surveillance and maintenance related work. Additionally, the station will continue to use double independent verification to ensure the proper removal and return to service of safety related and technical specification related equipment.