Commonwealth Edison
Braidwood Nuclear Power Station
Route #1, Box 84
Braceville, Illinois 60407
Telephone 815/458-2801

April 11, 1994
BW/94-0060

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

Dear Sir:

The enclosed Licensee Event Report from Braidwood Generating Station is being transmitted in accordance with the requirement of 10CFR50.73 (a)(2)(iv), which requires a 30-day written report.

This report is number 94-005-00, Docket No. 50-456.

K. L. Kofron
Station Manager
Braidwood Station

Encl: Licensee Event Report
No. 456/94-005-00

cc: NRC Region III Administrator
NRC Resident Inspector
INPO Record Center
CECo Distribution Center

IE22

NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Braidwood 1	05000456	1 OF 4

TITLE (4)
Inadvertant Start of 1B Diesel Generator During Surveillance Testing

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 NAME	DOCKET NUMBERS
									None	
03	23	94	94	-- 005 --	00	04	11	94	FACILITY NAME None	DOCKET NUMBER

OPERATING MODE (9)	6
POWER LEVEL (10)	000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (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
	20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)
	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	TELEPHONE NUMBER (Include Area Code)
A. Ficcardi, System Engineering	(815)458-2801 x2832

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)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE).	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On March 23, 1994, the 1B Diesel Generator Safety Injection (SI) and ESF Bus Undervoltage Surveillance Tests were in progress. Surveillance 1BwVS 8.1.1.2.f-16, 1B Diesel Generator Loss of ESF Bus Voltage with No SI Signal had been entered. At 0253, a miscommunication occurred, and ESF Bus 142 undervoltage relay was actuated by OAD personnel prior to the step in the procedure which called for this action. The plant response was per ESF design; 1B DG automatically started and appropriate B-train equipment sequenced on to Bus 142, per the safe shutdown sequencer. Operations personnel paralleled offsite power (SAT) to Bus 142 at 0303, and opened the 1B DG output breaker at 0307. The 1B DG was secured at 0322. The primary cause was a miscommunication. Contributing causes were high noise level in the area, inadequate pre-job briefing, and inadequate procedural adherence. Immediate corrective actions taken by Operations personnel were to restore offsite power to Bus 142 and then secure the 1B DG. Actions to be taken to prevent recurrence include the following items. The System Engineering Department will conduct training on 1) the hazards of communicating in high noise level areas, 2) HLA meeting expectations prior to performance of BwVS's, and 3) the expectations for Continuous Use procedures, specifically when more than one individual is performing steps. There have been no previous manual inadvertent ESF Bus UV actuations of this type.

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LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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Braidwood 1	05000456	94	-- 005 --	00	2 OF 4

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

A. PLANT CONDITIONS PRIOR TO EVENT

Unit: Braidwood Unit 1; Event Date: March 23, 1994
Event Time: 0253
Mode: 6 - Refueling; Rx Power: 0%
RCS Temperature/Pressure: 75 F/0 psig

B. DESCRIPTION OF EVENT:

The 1B Diesel Generator Safety Injection (SI) and ESF Bus Undervoltage Surveillance Tests were in progress on shift 1, March 23, 1994. The SI sequence test had been performed and the 1B Diesel Generator had been shutdown at 0230. Surveillance 1BwVS 8.1.1.2.f-16, 1B Diesel Generator Loss of ESF Bus Voltage with No SI Signal had been entered and completed through step F.1.14, just prior to starting the chart recorders and then actuating the Bus 142 undervoltage relay (DG1BX1). Personnel from OAD and System Engineering Department were at relay DG1BX1, confirming its location and the manner in which it would be actuated. At 0253, a miscommunication occurred, and relay DG1BX1 was actuated by OAD prior to the step in the procedure which called for this action. The plant response was per ESF design; Bus 142 was lost, 1B DG automatically started and the 1B Centrifugal Charging pump, 1B Component Cooling pump and 1B SX pump sequenced on to Bus 142, per the safe shutdown sequencer.

Operations personnel paralleled offsite power (SAT) to Bus 142 at 0303, and opened the 1B DG output breaker at 0307. The 1B DG was secured at 0322.

The appropriate Emergency Notification System (ENS) notification was made at 0436 EST pursuant to 10CFR50.72(b)(2)(ii).

This report is being submitted pursuant to 10CFR50.73(a)(2)(iv) - any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS).

C. CAUSE OF THE EVENT:

The primary cause of the event was a miscommunication between OAD and System Engineering Department personnel that occurred in the Division 12 ESF switchgear room immediately prior to the actuation of the relay.

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Contributing factors to the event include the following:

- The high noise level in the Division 12 ESF switchgear room.
- Inadequate Heightened Level of Awareness(HLA) pre-job briefing. BwAP 100-12 requires that "this meeting should describe the activity in detail to all participants to raise their level of awareness for performance of their tasks associated with the activity presented and determine the coordination necessary between work groups." The two people involved with actuating the relay were not in attendance at the HLA meeting, nor were the individuals given direction as to when and who would direct the relay actuation.
- Inadequate procedural adherence with BwAP 100-20 Procedure Use and Adherence, specifically Expectations for Continuous Use procedures (step D.8.c.1). The personnel did not read the surveillance procedure step for actuating the UV relay prior to performing the step.

D. SAFETY ANALYSIS:

This event had no effect on plant or public safety for the following reasons.

The plant response to the undervoltage signal was as designed. No system or component failures occurred prior to, during, or as a result of this event.

The A-train equipment was operable throughout the event, and required A-train equipment was in service, including 1A RH train in shutdown cooling mode.

If the undervoltage relay had actuated with the 1B DG and/or B-train equipment running, all the feed and load breakers to Bus 142 would open, the DG would start/switch to emergency mode, and B-train safe shutdown equipment would sequence on to the Bus. Any redundant equipment that started would be dealt with via existing plant procedures. If the 1B RH train had been in the shutdown cooling mode when the UV relay actuated, operator action would be required to restore shutdown cooling, using existing plant procedures.

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

E. CORRECTIVE ACTIONS

Operating personnel restored offsite power to Bus 142 and then secured the 1B DG.

Actions to be taken to prevent recurrence include the following items. The System Engineering Department will conduct training on 1) the hazards of communicating in high noise level areas, 2) HLA meeting expectations prior to performance of BwVS's, and 3) the expectations for Continuous Use procedures, specifically when more than one individual is performing steps.

F. PREVIOUS OCCURRENCES:

There have been no previous manual inadvertent ESF Bus UV actuations of this type.

G. COMPONENT FAILURE DATA:

This event was not the result of component failure, no did any components fail as a result of this event.