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Grand Gulf Nuclear Station

April 21, 1992

U.S. Nuclear Regulatory Commission  
Mail Station P1-137  
Washington, D.C. 20555

Attention: Document Control Desk

SUBJECT: Grand Gulf Nuclear Station  
Unit 1  
Docket No. 50-416  
License No. NPF-29  
Isolation Due to Inadvertent Breaker Operation  
LER 92-003

GNRO-92/00039

Gentlemen:

Attached is Licensee Event Report (LER) 92-003 which is a final report.

Yours truly,

*WTC*

WTC/RSJ/cg  
attachment

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 3054's) (17)

## A. Reportable Occurrence

On March 27, 1992, a Motor Control Center (MCC) power supply breaker was inadvertently opened momentarily which resulted in isolation of several Engineered Safety Feature (ESF) secondary containment valves. This event is being reported pursuant to 10CFR50.73(a)(2)(iv).

## B. Initial Conditions

The plant was operating at 100% reactor power at the time of occurrence.

## C. Description of Occurrence

On March 27, 1992, a non-licensed operator (NLO) was to hang a red tag on breaker 52-16404 for the Division II Hydrogen Recombiner load control center (LCC) prior to performance of a scheduled inspection and preventive maintenance instruction. Following identification of the breaker, the operator obtained the control room's permission to open 52-16404 but inadvertently opened feeder breaker 52-16403 to Motor Control Center (MCC) 16B instead. Breaker 52-16403 is located on load control center (LCC) 16BB4 directly above 52-16404. The operator immediately realized his mistake and reclosed 52-16403.

The inadvertent breaker opening resulted in closure of several air-operated secondary containment isolation valves and subsequent trip of the Plant Chilled Water System (EISS Code: KM). The valves are designed to fail close upon loss of supply air or power to their respective solenoid pilot valves.

The isolated valves were repositioned to their normally open position after the power supply breaker was closed. The Plant Chilled Water System was also returned to normal operation.

## D. Apparent Cause

The inadvertent breaker opening was primarily due to personnel error comprised of inattention to detail and lack of self verification.

Feeder breaker 52-16403 and power supply breaker 52-16404, which are located on LCC 16BB4 in close proximity to each other, was a contributing factor to the incident.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

## E. Supplemental Corrective Actions

The following corrective actions are in progress to preclude future incidents:

- o Operations is placing greater emphasis on the 'self-check and verification process' through Shift Seminars conducted by the Shift Superintendents.
- o All the other operators were made aware of the event.
- o The NLO was counseled on proper technique in self-check and verification.
- o A Human Performance Evaluation was initiated.

Meetings have recently been held concerning the recent trend of personnel error incidents to reiterate the importance of the individual's responsibility for self-verification, attention to detail, adherence to procedures, and precise communications during performance of work tasks.

## F. Safety Assessment

The event did not result in any adverse safety consequences. The breaker was immediately reclosed following operator error. The ESF isolation logic did not receive any other challenges during the period. The valves performed as designed upon deenergization of their respective solenoid pilot valves. No safety system function was adversely affected by the closure of the valves.