

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Calvert Cliffs, Unit 1 DOCKET NUMBER (2) 050003117 PAGE (3) 1 OF 02

TITLE (4) Inadvertent Initiation of Engineered Safety Features Actuation System

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 NAMES		DOCKET NUMBER(S)
07	24	84	84	007	00	08	23	84	N/A		05000
											05000

OPERATING MODE (9) <u>1</u>	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)									
	20.402(b)	20.406(c)	<input checked="" type="checkbox"/>	80.73(a)(2)(iv)	73.71(b)					
	20.406(a)(1)(i)	80.36(e)(1)		80.73(a)(2)(v)	73.71(c)					
	20.406(a)(1)(ii)	80.36(e)(2)		80.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 386A)					
	20.406(a)(1)(iii)	80.73(a)(2)(i)		80.73(a)(2)(viii)(A)						
	20.406(a)(1)(iv)	80.73(a)(2)(ii)		80.73(a)(2)(viii)(B)						
20.406(a)(1)(v)	80.73(a)(2)(iii)		80.73(a)(2)(x)							

LICENSEE CONTACT FOR THIS LER (12)

NAME <u>John Lohr, Operations Technical Advisor</u>	TELEPHONE NUMBER	
	AREA CODE <u>301</u>	<u>260-4776</u>

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)  NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (18)

During monthly surveillance testing of the engineered safety features actuation system, power was lost on a 4160 volt emergency bus when the operator performing the test inadvertently depressed the test button on under voltage logic module UV B-1 when the test procedure called for depressing the test button on under-voltage logic module UV B-4. Actuation of undervoltage logic module UV B-1 caused the normal feeder breaker to the 4160 volt emergency bus to trip open and left the bus deenergized. The error was quickly recognized and the 4160 volt emergency bus was reenergized within two minutes. To prevent recurrence of this incident the labeling of the undervoltage logic modules will be improved and all licensed operators will be apprised of the event.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Calvert Cliffs, Unit 1	DOCKET NUMBER (2)  0 5 0 0 0 3 1 7	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4	- 0 0 7	- 0 0	0 2	OF	0 2

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

At 1249 on July 24, 1984 power was lost to 4160 volt emergency bus 14 (EA-BU) during a monthly surveillance test of 4160 volt bus undervoltage actuation logic of the engineered safety features actuation system. The loss of power occurred to the 4160 volt emergency bus when the operator performing the test mistakenly initiated an actuation signal for undervoltage actuation logic module UV B-1 instead of logic module UV B-4 as required by the test procedure.

Undervoltage actuation logic module UV B-4 functions to start the diesel generator (DG) associated with 4160 volt emergency bus 14 and to initiate the load sequencer for that bus. Actuation of undervoltage actuation logic module UV B-4 will not cause any loads to be shed nor will any busses be deenergized.

Undervoltage actuation logic module UV B-1 functions to open the normal and alternate feeder breakers for 4160 volt emergency bus 14 should an undervoltage condition occur on the bus.

When the operator (a SRO) performing the test inadvertently initiated the UV B-1 undervoltage logic actuation module the normal feeder breaker for 4160 volt emergency bus 14 opened and the bus was deenergized. Once the 4160 volt emergency bus 14 was deenergized all undervoltage logic actuation modules for that bus activated resulting in a load shedding of the bus and starting of its associated diesel generator (the diesel generator will not automatically pick up the affected bus unless a safety injection actuation signal is present). Upon loss of power to 4160 volt emergency bus 14 the operators realized what had happened and reenergized the bus by closing its alternate feeder breaker and restarting those components which were load shed. The bus was reenergized within two minutes and all equipment returned to normal within the following ten minutes, thus terminating the event.

There was no other equipment inoperable which contributed to the event. The event did not result in a degradation of plant safety as 4160 volt emergency bus 14 was promptly reenergized and had any type of event occurred resulting in a safety injection action signal, 4160 volt emergency bus 14 would have been automatically reenergized by its associated diesel generator.

The cause of this event was the operator mistakenly pressing the test switch on the UV B-1 undervoltage actuation logic module instead of the UV B-4 test switch as required by the test procedure. The action taken to prevent a recurrence of this event or similar events will be to:

1. Improve the labeling on the engineered safety features actuation system such that all logic modules which cannot be tested during operation will be clearly identified.
2. The operator who initiated the event has written a report explaining the event which has been made required reading for all licensed operators.
3. The General Supervisor of Operations will discuss this event during normally scheduled meetings with licensed operators.

BALTIMORE GAS AND ELECTRIC COMPANY

P.O. BOX 1475

BALTIMORE, MARYLAND 21203

NUCLEAR POWER DEPARTMENT  
CALVERT CLIFFS NUCLEAR POWER PLANT  
LUSBY, MARYLAND 20657

August 23, 1984

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

Docket No. 50-317  
License No. DPR 53

Dear Sirs:

The attached LER 84-07 is being sent to you as required by  
10 CFR 50.73.

Should you have any questions regarding this report, we would  
be pleased to discuss them with you.

Very truly yours,

*L B Russell*

L. B. Russell  
Plant Superintendent

*SR*  
LBR:JFL:srm

cc: Dr. Thomas E. Murley  
Director, Office of Management Information  
and Program Control  
Messrs: A. E. Lundvall, Jr.  
J. A. Tiernan

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