Commonwealth Edison Company Braidwood Generating Station Route #1, Box 84 Braceville, IL 60407-9619 Tel 815-458-2801



January 10, 1996 BW/96-0009

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

Gentlemen:

The enclosed Licensee Event Report from Braidwood Generating Station is being transmitted in accordance with the requirement of 10 CFR 50.73(a)(2)(iv), which requires a 30-day written report.

This report is number 95-007-00, Docket No. 50-457.

Yours truly,

XJ. Tulon Station Manager Braidwood Nuclear Station

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Encl: Licensee Event Report No. 457-95-007-00

cc: NRC Region III administrator NRC Resident Inspector INPO Record Center ComEd Distribution Center I.D.N.S I.D.N.S Resident Inspector

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U.S. NUCLEAR REGULATORY COMMISSION (4-95) LICENSEE EVENT REPORT (LER)						APPROVED BY OMB NO. 3150-0104 EXPIRES 04/30/38 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE UCENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT									
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Emergency Diesel Generator on the Main Control Board in the Pull-To-Lock position, the Diesel Generator was inadvertently started. The Nuclear Station Operator had some difficulty operating the control switch when the initial attempt to place it in the Pull-To-Lock position failed. Upon returning the control switch to the normal after-trip position, the start contacts were made up by over rotation of the switch. The Diesel Generator and it's auxiliary equipment were verified to be functioning as designed following a start signal. The Diesel Generator was subsequently shutdown and placed in an Out-Of-Service condition as was the original intention. At 1128 CST, the appropriate NRC notification was made via the ENS phone system pursuant to 10CFR50.72(b)(2)(ii).

	U.S. NUCLEAR REGULAT	DRY COMMISSION	APPROVED BY OMB NO. 3150-0104 EXPIRES 04/30/98 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T- 6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT						
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

## A. PLANT CONDITIONS PRIOR TO EVENT:

UNIT: Braidwood Unit 2 EVENT DATE: 12/15/95 EVENT TIME: 0933 CST MODE: 1 RX POWER: 99.6% RCS [AB] TEMPERATURE/PRESSURE: NOT/NOP

### B. DESCRIPTION OF EVENT:

There were no systems or components inoperable at the beginning of this event that contributed to the severity of the event.

At 0933 on 12/15/95, the 2B Emergency Diesel Generator [EEB] was being taken Out-Of-Service (OOS) for relay testing. While attempting to place the control switch on the Main Control Board in the Pull-To-Lock position, the Diesel Generator was inadvertently started. The Nuclear Station Operator (NSO-RO Licensed) had some difficulty operating the control switch and the initial attempt to place it in the Pull-To-Lock position failed. Subsequent operations of the control switch could reveal no physical problems with the switch. The most probable cause for the initial problem was a failure to rotate the switch far enough to the left position to enable placing it in the Pull-Out position. Upon returning the control switch to the normal, After-Trip position, the control switch was over rotated such that close contacts for the breaker were made up. The NSO involved noted a half red/half green breaker flag configuration and audibly heard the Diesel Generator start. The NSO immediately matched switch flag targets, noted Diesel Generator run parameters to be satisfactory, and notified the Shift Supervisor (SRO Licensed) of the event.

An Equipment Operator (Non-Licensed) was sent to the Diesel Generator room to verify proper operation of the Diesel Generator. The Diesel Generator and it's auxiliary equipment were verified to be operating normally following the start signal.

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At 1128 CST, the appropriate NRC notification was made via the ENS phone system pursuant to 10CFR50.72(b)(2)(ii).

control switch in the Main Control Room in the Pull-To-Lock position as

required by the OOS with no problems experienced.

At 2151 the Diesel Generator was returned to service following completion of testing and successful performance of the Diesel Generator Monthly Operability Surveillance.

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

# C. CAUSE OF EVENT:

The cause of the event was personnel error during the manipulation of the control switch for the Diesel Generator breaker in the Main Control Room. The NSO operating the switch failed to properly position the control switch such that the initial attempt to place it in the Pull-To-Lock position failed. Upon returning the control switch to it's Normal After-Trip position, the switch was over rotated and the breaker start contacts made up to enable a start of the Diesel Generator.

# D. SAFETY ANALYSIS:

This event had no effect on the safety of the plant or the public. The 2B Emergency Diesel Generator and it's auxiliary equipment operated as designed following receipt of the manual start signal from the control room. All redundant Emergency Power Supplies were available during this event.

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

#### E. CORRECTIVE ACTIONS:

The control switch for the 2B Diesel Generator was checked for proper operation prior to returning the Diesel Generator to service. No abnormalities were found in the operation of the switch. The individual NSO involved was counseled on this event.

# F. PREVIOUS OCCURRENCES:

There has been one previous occurrence of Operator error/switch mispositioning resulting in an inadvertent ESF actuation at Braidwood Station.

LER 456-180-95-0180

A spurious Train B SSPS actuation occurred due to component failure, personnel error, and component interface design deficiency. On September 29,1990, the Train B SSPS initiated a Containment Ventilation Isolation Signal. During follow-up testing, a Reactor Operator (RO Licensed) inadvertently rotated the Train B SSPS Memories Test Switch from OFF to Position 23. This enabled the Pressurizer and Low Steam Line Pressure SI and Steam Line Isolation circuits which had been previously blocked . Corrective actions included reviewing this event as part of Licensed Operator Requalification Training.

# G. COMPONENT FAILURE DATA:

No components failed during or as a result of this event.