NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO 3150-0104
EXPIRES 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
LaSalle County Station Unit 1	0 5 0 0 0 3 7 3	1 OF 0 3

TITLE (4)
Loss of Bus 141Y and Auto-Start of Diesel ODG01K Due to Personnel Error

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)
									Unit 2	0 5 0 0 0 3 7 4
0 4	0 3	8 6	8 6	0 1 3	0 0	0 5	0 2	8 6		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
5		20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 0 0		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		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
James J. Hietala, Technical Staff Engineer, extension 463	AREA CODE 8 1 5 3 5 7 - 6 7 6 1

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	
A	E B	5 1	W 1 2 1	N							

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 fifteen single-space typewritten lines) (16)

At 1410 hours on April 3, 1986, an Operational Analysis Department technician inadvertently tripped an overcurrent relay for the System Auxiliary Transformer. Offsite power was lost to the Unit 1, Division 1 Bus 141Y. The diesel generator auto-started and closed onto the bus. All systems operated per design, just as if an actual overcurrent had occurred. Personnel error caused the event, by not isolating the relay prior to working on it. The relay had just been calibrated and returned to service. Training will be given to isolate relays, prior to doing any work on them.

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

I. DESCRIPTION OF OCCURRENCE:

At 1410 hours on April 3, 1986, an overcurrent signal was received from the C phase of the System Auxiliary Transformer (SAT, EL). Per design, the SAT feed breaker to Bus 141Y (EB), Air Circuit Breaker (ACB) 1412, tripped open. Also the bus crosstie breaker, ACB 1415, tripped, as designed. The "0" Diesel Generator (EK) auto-started on Bus 141Y undervoltage, and its output breaker closed onto Bus 141Y. The transient caused trips of Reactor Building Ventilation (VR, VA) and Reactor Water Clean-up pumps (RT, CE). Unit 1 was shutdown for refueling and was defueled at the time of the event. Offsite power was returned to Bus 141Y through the Unit Auxiliary Transformer (UAT, EL) at 1420 hours. The "0" Diesel Generator was then shutdown at 1430 hours. After the initial overcurrent signal, all systems functioned per their design. This is an Engineered Safety Feature (ESF) actuation.

II. CAUSE:

The cause for the overcurrent signal was an inadvertent trip initiated by Operational Analysis Department (OAD) personnel during the overcurrent relays return to service. The overcurrent relay (1451-AP024B) had been removed from service (test switches opened) and removed from the switchgear for a calibration check. After the calibration was complete, the relay was returned to the switchgear cabinet. Test knife switches for the relay were still open and the relay was functionally checked in place. Other relays were being installed in this switchgear and functionally checked at the same time. After all the relays were checked, the test knife switches were closed (enabling the relay trips). The OAD personnel were then resetting the targets (trip indicators) that were caused by the functional check. He noted that the C phase overcurrent relay target was not indicating. He was physically checking the target problem when he inadvertently closed the ICS contact on the relay, thus causing an actual trip. Since the test knife switch was closed, the circuit functioned just as if an overcurrent had occurred. The relay is a Westinghouse type CO-6 overcurrent relay.

III. PROBABLE CONSEQUENCES OF THE OCCURRENCE:

All systems operated per design, as if an overcurrent had occurred. The diesel generator auto-started and energized the 141Y bus. Offsite power was restored in 10 minutes. Unit 2 operation was not affected in that if a LOCA signal and undervoltage on Unit 2 Bus 241Y occurred the "0" Diesel Generator would have transferred to Unit 2.

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

IV. CORRECTIVE ACTIONS:

The OAD personnel did not follow standard practice when he worked on the relay without isolating it. LaSalle OAD personnel will be trained on the importance of isolating relays from the circuit when any work is being performed on them. AIR 373-200-86-03500 will document the training completion. The target that apparently had not operated during the functional check worked properly when the inadvertent trip occurred. Further inspection revealed no problems with the target operation.

V. PREVIOUS OCCURRENCES:

There have been no previous occurrences of OAD personnel tripping relays inadvertently while the relays were not isolated.

VI. NAME AND TELEPHONE NUMBER OF PREPARER:

James J. Hietala, Technical Staff Engineer, 815/357-6761, extension 463.

Commonwealth Edison
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Rural Route #1, Box 220
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May 2, 1986

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

Dear Sir:

Reportable Occurrence Report #86-013-00, Docket #050-373 is being submitted to your office in accordance with 10CFR 50.73.

for R. D. Bishop
G. J. Diederich
Station Manager
LaSalle County Station

GJD/DRR/kg

Enclosure

xc: NRC, Regional Director
INPO-Records Center
File/NRC

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