

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) PRAIRIE ISLAND UNIT 1 DOCKET NUMBER (2) 0 5 0 0 0 2 8 1 2 1 OF 0 2

TITLE (4)

INADVERTENT START OF A DIESEL GENERATOR 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)						
0	4	1	3	8	9	8	9	0	0	3	0	0	0	3	1	0	6
0	4	1	3	8	9	8	9	0	0	3	0	0	0	3	1	0	6

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																					
POWER LEVEL (10)	1 0 0	20.402(b)	20.405(a)(1)(i)	20.405(a)(1)(ii)	20.405(a)(1)(iii)	20.405(a)(1)(iv)	20.405(a)(1)(v)	20.405(e)	50.36(e)(1)	50.36(e)(2)	50.73(a)(2)(i)	50.73(a)(2)(ii)	50.73(a)(2)(iii)	50.73(a)(2)(iv)	50.73(a)(2)(v)	50.73(a)(2)(vi)	50.73(a)(2)(vii)(A)	50.73(a)(2)(vii)(B)	50.73(a)(2)(viii)	50.73(a)(2)(ix)	73.71(b)	73.71(c)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)

LICENSEE CONTACT FOR THIS LER (12)
NAME Arne A Hunstad, Staff Engineer
TELEPHONE NUMBER 6 1 2 3 8 8 - 1 1 2 1
AREA CODE 6 1 2 3 8 8 - 1 1 2 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)									
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)
YES (If yes, complete EXPECTED SUBMISSION DATE) X NO
EXPECTED SUBMISSION DATE (15)

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

On April 13, 1989, Unit 1 was at 100% power and Unit 2 was at cold shutdown for refueling. During performance of the routine surveillance procedure for testing the Bus 26 Voltage Restoration Scheme, the expected response for one of the procedure steps was not obtained. Work on the test was stopped while an evaluation of the problem was conducted. It was discovered that the workman performing the test had missed a step in the procedure and had not returned the selector switch for the Bus-tie Breaker 26-8 to the Auto position. By the time the evaluation was complete, D1 Diesel Generator, which had been running as a normal result of the test, had already been shut down and returned to normal standby condition.

It is required to have D1 Diesel Generator running for the completion of the test, but another diesel start was not desired, so steps were taken to simulate D1 running. A work package was prepared which included a marked-up copy of the remainder of the procedure and a listing of the necessary bypasses. The work package was in error, however, in that it directed the application of the bypasses at the incorrect time. The result was that D1 Diesel Generator started inadvertently at 2050.

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PDR ADDCK 05000282
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Prairie Island Unit 1	0 5 0 0 0 2 8 2	8 9	— 0 0 3	— 0 0	0 2	OF	0 2

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

EVENT DESCRIPTION

On April 13, 1989, Unit 1 was at 100% power and Unit 2 was at cold shutdown for refueling. During performance of the routine surveillance procedure for testing the Bus 26 Voltage Restoration Scheme (EIS Identifier EK), the expected response for one of the procedure steps was not obtained. Work on the test was stopped while an evaluation of the problem was conducted. It was discovered that the workman performing the test had missed a step in the procedure and had not returned the selector switch for the Bus-tie Breaker 26-8 (EIS Identifier BKR) to the Auto position. By the time the evaluation was complete, D1 Diesel Generator (EIS Identifier DG), which had been running as a normal result of the test, had already been shut down and returned to normal standby condition.

It is required to have D1 Diesel Generator running for the completion of the test, but another diesel start was not desired, so steps were taken to simulate D1 running. A work package was prepared which included a marked-up copy of the remainder of the procedure and a listing of the necessary bypasses. The work package was in error, however, in that it directed the application of the bypasses at the incorrect time. The result was that D1 Diesel Generator started inadvertently at 2050.

CAUSE OF THE EVENT

The cause of the event is personnel error. The worker performing the test was apparently distracted from the flow of the procedure when he notified fellow operators of the next evolution in the test. When he returned to the procedure, he missed a step which would have placed the bus-tie breaker control switch in the proper position.

The second error was made in preparation of the work package, which directed the application of bypasses at the wrong time.

ANALYSIS OF THE EVENT

This event is reportable under 10CFR50.73.(a)(2)(iv). There was no effect on public health and safety since all equipment operated as designed.

CORRECTIVE ACTION

Test procedures will be reviewed with the intent of improving human factor considerations and minimizing distractions. Involved personnel have been counseled concerning this event.

PREVIOUS SIMILAR EVENTS

The last auto-start of a diesel generator was reported as Unit 1 LER 87-010, although the circumstances were not at all similar.



Northern States Power Company

414 Nicollet Mall
Minneapolis, Minnesota 55401-1927
Telephone (612) 330-5500

May 12, 1989

10 CFR Part 50
Section 50.73

Director of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

PRAIRIE ISLAND NUCLEAR GENERATING PLANT
Docket Nos. 50-282 License Nos. DPR-42
50-306 DPR-60

Inadvertent Start of a Diesel
Generator Due to Personnel Error

The Licensee Event Report for this occurrence is attached.

Please contact us if you require additional information related to this event.

David M Musolf
Manager - Nuclear Support Services

c: Regional Administrator - III, NRC
Sr Resident Inspector, NRC
NRR Project Manager, NRC
MPCA
Attn: Dr J W Ferman

Attachment

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11