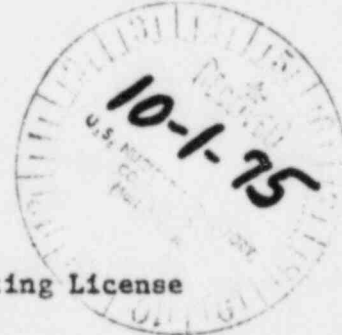


P. O. Box 361, Platteville, Colorado 80651

September 26, 1975

Mr. E. Morris Howard, Director  
Nuclear Regulatory Commission  
Region IV  
Office of Inspection and Enforcement  
Suite 1000  
Arlington, Texas 76012



Ref: Facility Operating License  
No. DPR-34

Docket No. 50-267

IE FILE COPY

Dear Mr. Howard:

Enclosed please find a copy of Abnormal Occurrence Report No. 50-267/75/23,  
Final, submitted per the requirements of the Technical Specifications.

Very truly yours,

Frederic E. Swart  
Superintendent, Nuclear Production  
Fort St. Vrain Nuclear  
Generating Station

FES/alk

cc: Mr. Roger S. Boyd

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COPY SENT REGION IV

10400

REPORT DATE: September 26, 1975

ABNORMAL OCCURRENCE 75/23

Page 1 of 4

OCCURRENCE DATE: September 16, 1975

FORT ST. VRAIN NUCLEAR GENERATING STATION  
PUBLIC SERVICE COMPANY OF COLORADO  
P. O. BOX 361  
PLATTEVILLE, COLORADO 80651

REPORT NO. 50-267/75/23

Final

IDENTIFICATION OF  
OCCURRENCE:

On September 16, 1975, at 1700 hours, an essential electrical cable was discovered to have failed. This was identified as an abnormal occurrence per Section 2.1 (f) of the Fort St. Vrain Technical Specifications. Further investigation indicates that the initial evaluation was incorrect, and that this should have been categorized as an Unusual Event.

CONDITIONS PRIOR  
TO OCCURRENCE:

<u>Steady State Power</u>	<u>Routine Shut down</u>
<u>Hot Shutdown</u>	<u>Routine Load Change</u>
<u>X Cold Shutdown</u>	<u>Other (specify)</u>
<u>Refueling Shutdown</u>	<u></u>
<u>Routine Startup</u>	<u></u>

The major plant parameters at the time of the event were as follows:

Power	RTR	0	MWth
	ELECT	0	MWe
Secondary Coolant	Pressure	200	psig
	Temperature	80	°F
	Flow	400,000	#/hr.
Primary Coolant	Pressure	12.8	psia
	Temperature	84	°F Core Inlet
		84	°F Core Outlet
	Flow	0	#/hr.

DESCRIPTION OF  
OCCURRENCE:

On September 16, 1975, the control room operators received an alarm indicating that the 480V feed to battery charger 1B had tripped open (reference figure 3.2-8.)

The shift supervisor on duty proceeded to the 480V switchgear room to investigate and upon entering observed smoke and the odor of burnt insulation. Two construction electricians had been "chasing cables" in the area and reported to the shift supervisor that while pulling on cable number 3525, they had observed a large flash.

APPARENT CAUSE  
OF OCCURRENCE:

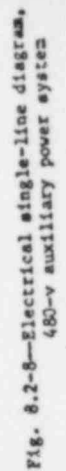
<u>                    </u> Design	<u>                    </u> Unusual Service Cond. Including Environ.
<u>                    </u> Manufacture	<u>                    </u> Component Failure
<u>                    </u> Installation/Const.	<u>      X      </u> Other (specify)
<u>                    </u> Operator	<u>                    </u> Circumstances associated with
<u>                    </u> Procedure	<u>                    </u> work in progress.

ANALYSIS OF  
OCCURRENCE:

Investigation revealed that cable number 3525 is the 480V feed from 480V essential bus number 3 to battery charger 1B. The two construction electricians had been in the process of verifying the routing of cable number 3525 and in so doing, had found it necessary to pull on this cable. In the process of pulling on this cable, the cable shifted in the cable tray and contacted the sharp metal edge of a cable tray hanger. Unaware that the cable was in contact with this sharp edge, the electricians continued to pull on the cable, and in doing so, cut through the cable insulation allowing the conductor to contact the grounded hanger, tripping the battery charger feed breaker open.

CORRECTIVE  
ACTION:

The damaged cable will be replaced during the effort to correct essential cable separation and segregation.



Assessment 15

FAILURE DATA/SIMILAR REPORTED OCCURRENCES:

None

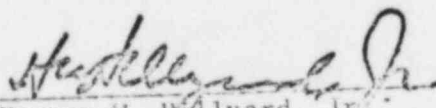
PROGRAMMATIC IMPACT:

None

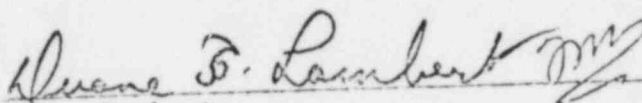
CODE IMPACT:

None

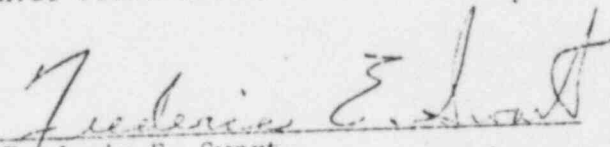
Submitted By:

  
Harvey W. Willyard, Jr.  
Technical Services Supervisor

Reviewed By:

  
Duane Lambert  
Supervisor, Denver Plant Electricians

Approved by:

  
Frederic E. Swart  
Superintendent, Nuclear Production