

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) McGuire Nuclear Station - Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 6 0	PAGE (3) 1 OF 0 2
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TITLE (4) Momentary Blackout on Unit 1 Train "B"									
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EVENT DATE (6)			LER NUMBER (8)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)										
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)								
1	0	3	0	8	5	8	5	0	3	3	0	0	1	2	0	5	0	0	0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
OPERATING MODE (9) 1		20.402(b)		20.406(c)		<input checked="" type="checkbox"/> 50.73(a)(2)(iv)		73.71(b)	
POWER LEVEL (10) 1 0 0		20.406(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)	
		20.406(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
		20.406(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)			
		20.406(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)			
		20.406(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(ix)			

LICENSEE CONTACT FOR THIS LER (12)									
NAME Jerry Day, Licensing									
TELEPHONE NUMBER AREA CODE 7 0 4 3 7 3 - 7 0 3 3									

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)										EXPECTED SUBMISSION DATE (15)		
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)										<input checked="" type="checkbox"/> NO		
										MONTH DAY YEAR		

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

On October 30, 1985 during testing of Diesel Generator (D/G) 1B, a Nuclear Control Operator (NCO) inadvertently opened the D/G breaker while trying to adjust D/G frequency. This caused a blackout of Train "B". The blackout signal restarted the D/G and the sequencer applied loads to the bus.

This incident is attributed to personnel error because the NCO pushed the wrong button, stopping the D/G.

All systems and personnel responded properly to the blackout signal. This incident will be reviewed with personnel.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
McGuire Nuclear Station - Unit 1	0500036985	—	033	—00	02	OF	02

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

On October 30, 1985 at 2140, D/G 1B was started to perform D/G 1B Operability Test. At 2258, while D/G 1B was supplying power to 1ETB bus, the D/G breaker was inadvertently opened causing a blackout of Unit 1 B Train.

Unit 1 was in Mode 1 at 100% power at the time of the incident.

This incident is attributed to Personnel Error. The Operations Nuclear Control Operator (NCO) inadvertently opened the D/G breaker while trying to adjust D/G frequency.

Description of Event

After it was determined that the D/G 1B start at 1900 was an invalid failure (reference H.B. Tucker's December 2, 1985 letter to J. Nelson Grace, RII), an NCO started D/G 1B to repeat the operability test. The NCO was performing the test remotely from the control room. The NCO was familiar with the test and had successfully performed the test prior to this event. After loading the D/G to 4000 KW for one hour, the NCO reduced load until the D/G was carrying the actual 1ETB bus load. The NCO then opened the normal incoming breaker to 1ETB to verify that the D/G could carry 1ETB bus. After having adjusted frequency of the D/G down once, the NCO again tried to adjust frequency down. A personnel error occurred when the NCO accidentally pushed the D/G stop button instead of the governor control push button. The two pushbuttons are side by side.

One second after D/G 1B breaker opened, the D/G restarted on a blackout signal. After control room personnel had implemented the necessary procedures to recover from the blackout, the NCO closed the normal incoming breaker to 1ETB bus. The NCO then opened the D/G 1B breaker and shutdown the D/G. The NCO used these last few steps to complete the D/G operability test, since the D/G had already met all the criteria for a valid successful test. This was not in conflict with T.S. requirements.

A review of past Incidents indicate there are no past reports involving personnel error due to an operator pushing the wrong button causing a blackout. There, this is considered to be an isolated incident.

CORRECTIVE ACTIONS:

- Subsequent:
- 1) All necessary procedures for a blackout were implemented.
 - 2) The personnel error incident was discussed with the involved personnel.
 - 3) Collars with plastic slide tops have been installed on all four D/G stop pushbuttons in the Control Room to prevent an accidental actuation.

Planned: The incident will be covered with all Operations shift personnel.

SAFETY ANALYSIS:

D/G 1B performed as designed. It started on the resulting blackout signal, the D/G breaker closed, and the sequencer applied loads to 1ETB bus. Also Train A was available at all times during the Train B blackout.

The health and safety of the public were not affected by this incident.

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VICE PRESIDENT
NUCLEAR PRODUCTION

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December 2, 1985

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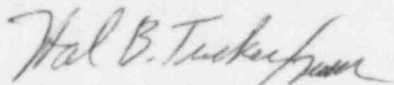
Subject: McGuire Nuclear Station, Unit 1
Docket No. 50-369
LER 369/85-33

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a)(1) and (d), attached is Licensee Event Report 369/85-33 concerning a momentary blackout on Train "B".

This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,



Hal B. Tucker

JBD/jgm

Attachment

cc: Dr. J. Nelson Grace, Regional Administrator
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