JUN 21 1983

GPU Nuclear

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Writer"s Direct Dial Number:

May 18, 1983
4410-83-L-0105

B & W

Office of Inspection and Enforcement
Attn: Mr. J. M. Allan
Acting Regional Administrator
Region I
US Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73
Docket No. 50-320
Licensee Event Report 83-013/03L-0

Attached please find Licensee Event Report 83-013/03L-0 concerning the inadvertent opening of a circuit breaker on April 18, 1983.

This event concerns Sections 3.3.3.7, 3.9.12.1, and 3.9.12.2 and is considered reportable under Section 6.9.1.9(b) of the Interim Recovery Technical Specifications.

Sincerely,

B. K. Kanga

B. K. Kanga
Director, TMI-2

BKK/RDW/jep

Attachments

CC: Mr. L. H. Barrett, Deputy Program Director - TMI Program Office
Dr. B. J. Snyder, Program Director - TMI Program Office

IE22

LER 83-013/03L-0
EVENT DATE - April 18, 1983

I. EXPLANATION OF OCCURRENCE

At 1130 hours on April 18, 1983, a Control Room Operator (CRO) went to the Control Building Cable Room to perform a switching order. The switching order was to open Breaker No. 20 in Cabinet MPC-1A. The CRO inadvertently opened Breaker No. 14 which tripped the Auxiliary and Fuel Handling Building Ventilation Systems, and the Air Intake Tunnel and Control Building Chlorine Monitors. This resulted in the annunciation of the associated alarms in the Control Room.

Upon verification of his action, the CRO realized the mistake and reclosed Breaker No. 14. The Auxiliary Building Ventilation System, Fuel Handling Building Ventilation System, and the Air Intake Tunnel and Control Building Chlorine Monitors were returned to service at 1200 hours on April 18, 1983.

This event is considered reportable pursuant to Technical Specification 6.9.1.9(b) due to entry into and compliance with the Action Statements of Technical Specification 3.3.3.7, 3.9.12.1, and 3.9.12.2.

II. CAUSE OF THE OCCURRENCE

The cause of the event was personnel error as a result of the CRO inadvertently opening the wrong breaker. Upon opening Cabinet MPC-1A, the CRO glanced at the lower section of the cabinet where he remembered Breaker No. 20 was located. The number he recognized as "20" was, in actuality, "20 amp" stamped on Breaker No. 14. Seeing the number "20", the CRO opened the breaker.

III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

At the time of the occurrence, the Unit 2 facility was in a long-term cold shutdown state. The reactor decay heat was being removed via loss to ambient. Throughout the event there was no effect on the Reactor Coolant System or the core.

IV. CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN

Immediate

Upon verification of his action, the CRO realized the mistake and reclosed Breaker No. 14. The Auxiliary Building Ventilation System, Fuel Handling Building Ventilation System, and the Air Intake Tunnel and Control Building Chlorine Monitors were returned to service.

Long-Term

The CRO was counseled regarding the outcome of the event.

NRC FORM 366 (7-77)

Operator opens wrong breaker

LICENSEE EVENT REPORT

U. S. NUCLEAR REGULATORY COMMISSION
Attachment 1
4410-83-L-0105

CONTROL BLOCK: 1 8 3 8 5 4 (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Three Mile Island 2

0 1 | P A T M I 2 (2) | 0 0 - 0 0 0 0 0 - 0 0 (3) | 4 1 1 1 1 (4) | (5)
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

CON'T
0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 3 2 0 (7) | 0 4 1 8 8 3 (8) | 0 5 1 8 8 3 (9)
7 8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | At 1130 hours on April 18, 1983, a Control Room Operator (CRO) inadvertently opened a
0 3 | wrong breaker, thus tripping the Auxiliary and Fuel Handling Building Ventilation
0 4 | Systems and the Control Building Chlorine Monitors. The breaker was reclosed and all
0 5 | systems restarted. This event is considered reportable pursuant to Section 6.9.1.9(b)
0 6 | due to entry into and compliance with the Action Statement of Technical Specifications
0 7 | 3.3.3.7, 3.9.12.1, and 3.9.12.2. This event had no effect on the health and safety
0 8 | of the public.
7 8 9 80

5-26-83

0 9 | SYSTEM CODE E G (11) | CAUSE CODE A (12) | CAUSE SUBCODE A (13) | COMPONENT CODE C K T B R K (14) | COMP. SUBCODE A (15) | VALVE SUBCODE Z (16)
7 8 9 10 11 12 13 18 19 20

(17) LER/RO REPORT NUMBER | EVENT YEAR 8 3 | — | SEQUENTIAL REPORT NO. 0 1 3 | / | OCCURRENCE CODE 0 3 | REPORT TYPE L | — | REVISION NO. 0
21 22 23 24 26 27 28 29 30 31 32

ACTION TAKEN X (18) | FUTURE ACTION H (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS (22) 0 0 0 0 | ATTACHMENT SUBMITTED Y (23) | NPRD-4 FORM SUB. N (24) | PRIME COMP. SUPPLIER Z (25) | COMPONENT MANUFACTURER Z 9 9 9 (26)
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The CRO inadvertently mistook "20 amp" stamped on breaker 14 of cabinet MPC-1A as
1 1 | Breaker "20". Upon verification of his action, the CRO realized the mistake and
1 2 | reclosed Breaker 14. All systems were returned to service. The CRO was counseled
1 3 | regarding the outcome of this event.
1 4 |
7 8 9 80

1 5 | FACILITY STATUS X (28) | % POWER 0 0 0 (29) | OTHER STATUS (30) Recovery Mode | METHOD OF DISCOVERY A (31) | DISCOVERY DESCRIPTION (32) Operator discovery
7 8 9 10 12 13 44 45 46 80

1 6 | ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) N/A | LOCATION OF RELEASE (36) N/A
7 8 9 10 11 44 45 80

1 7 | PERSONNEL EXPOSURES NUMBER 0 0 0 (37) | TYPE Z (38) | DESCRIPTION (39) N/A
7 8 9 11 12 13 80

1 8 | PERSONNEL INJURIES NUMBER 0 0 0 (40) | DESCRIPTION (41) N/A
7 8 9 11 12 80

1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) | DESCRIPTION (43) N/A
7 8 9 10 80

2 0 | PUBLICITY ISSUED N (44) | DESCRIPTION (45)
7 8 9 10

8306010329 830518
PDR ADOCK 05000320
S PDR

NRC USE ONLY
68 69 80

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GPO 91-928