

June 5, 2006

SVPLTR # 06-0032

U. S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, DC 20555-0001

Dresden Nuclear Power Station, Unit No. 2  
Renewed Facility Operating License No. DRP-19  
NRC Docket No. 50-237

Subject: Licensee Event Report 237/2006-002-00, "Unit 2 High Pressure Coolant Injection System Declared Inoperable"

Enclosed is Licensee Event Report 237/2006-002-00, "Unit 2 High Pressure Coolant Injection System Declared Inoperable," for Dresden Nuclear Power Station, Unit 2. This event is being reported in accordance with 10 CFR 50.73(a)(2)(v)(D), "Any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident."

Should you have any questions concerning this report, please contact Mr. J. Ellis, Regulatory Assurance Manager, at (815) 416-2800.

Respectfully,



Danny G. Bost  
Site Vice President  
Dresden Nuclear Power Station

Enclosure

cc: Regional Administrator – NRC Region III  
NRC Senior Resident Inspector – Dresden Nuclear Power Station

*JE22*

### LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

<b>1. FACILITY NAME</b> Dresden Nuclear Power Station Unit 2	<b>2. DOCKET NUMBER</b> 05000237	<b>3. PAGE</b> 1 OF 4
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**4. TITLE**  
Unit 2 High Pressure Coolant Injection System Declared Inoperable

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
04	06	2006	2006	- 002 -	00	06	05	2006	N/A	N/A
									FACILITY NAME	DOCKET NUMBER
									N/A	N/A

<b>9. OPERATING MODE</b>  1	<b>11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§:</b> (Check all that apply)									
<b>10. POWER LEVEL</b>  097	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)						
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)						
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)						
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)						
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER							
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)(D)								

Specify in Abstract below or in NRC Form 366A

**12. LICENSEE CONTACT FOR THIS LER**

FACILITY NAME Dresden Nuclear Power Station – George Papanic Jr.	TELEPHONE NUMBER (Include Area Code) (815) 416-2815
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**13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT**

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
NA					NA				

<b>14. SUPPLEMENTAL REPORT EXPECTED</b>				<b>15. EXPECTED SUBMISSION DATE</b>		
<input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO				MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On April 6, 2006, at approximately 1039 hours (CDT), with Unit 2 at approximately 97 percent power, Dresden Nuclear Power Station Instrument Maintenance technicians were installing a new High Pressure Coolant Injection System temperature recorder 2-2340-9 when an energized recorder electrical lead was accidentally shorted to a recorder mounting bracket screw. A consequence of this electrical short was the transfer of the Essential Service System to its emergency power supply from Motor Control Center 28-2 and the trip of Essential Service System circuit 16. This resulted in the High Pressure Coolant Injection System being declared inoperable due to a loss of its automatic function from the loss of power to its flow controller and signal converter. However, the system was available due to control room personnel being able to manually control system operation.

The apparent cause of this event was human performance associated with the technicians' lack of attention to detail in manipulating tools and failure to self-check. Corrective actions addressed the human performance issues through discussions of this event with the IM technicians during department training sessions and the evaluation the technicians during out-of-the-box training for proper use of human performance tools. These corrective actions reinforced the need for self-checking and the use of tape on adjacent metal components when working with energized electrical leads.



**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Dresden Nuclear Power Station Unit 2	05000237	2006	-- 002	-- 00	3 OF 4

**NARRATIVE** (If more space is required, use additional copies of NRC Form 366A) (17)

While a technician was attempting to land the hot power lead, the lead came in contact with the mounting bracket screw for the recorder, which caused a short to ground. The event occurred following the technicians return from a morning break. A self-checking drill was not performed when returning to the job site. Failure to perform the self-checking drill and a lack of attention to detail resulted in the technicians not noticing that the mounting bracket screw was only 1/4" away from the power lead terminal. Had the technicians noticed the close proximity of the mounting screw and taped it off, the event would have been prevented. During the evolution all correct safety attire was worn and no one was injured.

**D. Safety Analysis:**

The safety significance of the event is minimal. Technical Specification (TS) 3.5.1, ECCS - Operating," allows Unit 2 to remain at power for 14 days with an inoperable HPCI if the Isolation Condenser System (IC) is operable. Unit 2 was in compliance with TS 3.5.1 during this event as the IC was operable and HPCI was inoperable for approximately 8 hours. ESS circuit 16 supplies power to the HPCI signal converter and the flow controller. As a result of the power being lost, HPCI would not automatically ramp to full speed to supply the required injection flow to the reactor vessel. Although the automatic function was affected, the control room personnel maintained the ability to manually control the turbine speed to achieve the required system injection flow. Therefore, the consequences of this event had minimal impact on the health and safety of the public and reactor safety.

**E. Corrective Actions:**

Corrective actions addressed the human performance issues through discussions of this event with the IM technicians during department training sessions and the evaluation the technicians during out-of-the-box training for proper use of human performance tools. These corrective actions reinforced the need for self-checking and the use of tape on adjacent metal components when working with energized electrical leads.

**F. Previous Occurrences:**

A review of DNPS Licensee Event Reports (LERs) for the last three years identified two LERs associated with human performance.

LER 237/2004-001, "Unit 2 High Pressure Coolant Injection System Inoperable due to Lifted Leads," dated June 11, 2004. This LER reported on the failure of technicians to reconnect electrical leads after a surveillance was stopped. The corrective actions from this LER address the control of action associated with activities not completed in their entirety. This event and associated corrective actions are not similar to and would not have prevented this event.

LICENSEE EVENT REPORT (LER)

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		2006	-- 002	-- 00		

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

LER 237/2003-001, "Electromatic Relief Valve (ERV) Pressure Switches Drift Greater Than Estimated," dated July 18, 2003. This LER reported a calculation error and ineffective implementation of previous corrective actions to implement an appropriate setpoint. This event and associated corrective actions are not similar to and would not have prevented this event.

G. Component Failure Data:

NA