

SVPLTR # 11-0054

December 16, 2011

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

Dresden Nuclear Power Station, Units 2 and 3
Renewed Facility Operating License Nos. DPR-19 and DPR-25
NRC Docket Nos. 50-237 and 50-249

Subject: Licensee Event Report 237/2011-004-00, Personnel Error Results in Control Room Emergency Ventilation Air Conditioning System Inoperability

Enclosed is Licensee Event Report 237/2011-004-00, "Personnel Error Results in Control Room Emergency Ventilation Air Conditioning System Inoperability." 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.

There are no regulatory commitments contained in this submittal.

Should you have any questions concerning this letter, please contact Mr. Dennis Leggett at (815) 416-2800.

Respectfully,



for
David M. Czufin
Site Vice President
Dresden Nuclear Power Station

Enclosure

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

IEZZ
NRR

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: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@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.

1. FACILITY NAME Dresden Nuclear Power Station, Unit 2	2. DOCKET NUMBER 05000237	3. PAGE 1 OF 3
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4. TITLE
Personnel Error Results in Control Room Emergency Ventilation Air Conditioning System Inoperability

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
10	24	2011	2011	- 004 -	00	12	16	2011	Dresden Unit 3	05000249
									FACILITY NAME	DOCKET NUMBER
									N/A	05000

9. OPERATING MODE 5(1)	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: <i>(Check all that apply)</i>
10. POWER LEVEL 000(100)	<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)(vii)(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) <input type="checkbox"/> OTHER <div style="text-align: right; font-size: small;">Specify in Abstract below or in NRC Form 366A</div>

12. LICENSEE CONTACT FOR THIS LER

NAME Riley Ruffin – Licensing Engineer	TELEPHONE NUMBER <i>(Include Area Code)</i> 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

14. SUPPLEMENTAL REPORT EXPECTED <input type="checkbox"/> YES <i>(If yes, complete 15. EXPECTED SUBMISSION DATE)</i> <input checked="" type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE MONTH: DAY: YEAR:
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ABSTRACT *(Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)*

On October 24, 2011, during refueling activities, plant personnel were performing an in-field verification of a clearance order protective boundary. During this safety walkdown, a maintenance technician opened a Division I 4kV bus compartment which contained the bus potential fuses erroneously. The fuses are directly connected to the compartment drawer. Therefore, the fuses are removed from their fuse holders as the drawer is opened. As the fuses were removed, the 4kV bus sensed an undervoltage condition and loads fed by the 4kV bus received a load shed signal.

The Control Room Emergency Ventilation Air Conditioning (CREVAC) system was aligned to the Division I Containment Cooling Service Water (CCSW) system. As a result of the load shed signal, the CCSW system was not capable of supplying cooling flow to the CREVAC system. The cause of the event is due to personnel error. The technician failed to utilize human error prevention tools prior to opening the 4kV bus compartment. Personnel involved were coached. Additionally, an evaluation of robust barriers for bus pot fuse compartments is being performed.

The safety significance of this condition is low. The fuses were removed for approximately seven seconds. The Control Room Emergency Ventilation system is required to be initiated within forty minutes following an accident. Due to short duration of the inoperability, the health and safety of the public and plant employees were not compromised as a result of this condition.

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.

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Dresden Nuclear Power Station, Unit 2	05000237	YEAR	SEQUENTIAL NUMBER	REV NO.	2	OF	3
		2011	- 004	- 00			

NARRATIVE

PLANT AND SYSTEM IDENTIFICATION

Dresden Nuclear Power Station (DNPS) Units 2 and 3 are General Electric Company Boiling Water Reactors with a licensed maximum power level of 2957 megawatts thermal. The Energy Industry Identification System codes used in the text are identified as [XX].

A. Plant Conditions Prior to Event:

Unit: 02(03)	Event Date: 10-24-2011	Event Time: 1037 hours CDT
Reactor Mode: 5(1)	Mode Name: Refueling(Power Operation)	Power Level: 000(100) percent

B. Description of Event:

On October 24, 2011, at approximately 1037 CDT, plant personnel were performing an in-field verification of a clearance order protective boundary in preparation for maintenance activities. During the walkdown, a maintenance technician went to Division I 4kV Bus 23 [EB] and proceeded to verify that bus potential fuses had been removed to accommodate electrical maintenance work activities. The fuses to support the work activity were located in the lower fuse compartment at Bus 23. However, the technician erroneously opened the upper compartment, which contained fuses for Bus 23. By design, the fuses are directly connected to the compartment drawer; therefore, when the drawer is opened the fuses are removed from their fuse holders. This resulted in loads that were being supplied by Bus 23 to automatically load shed.

The Division I Containment Cooling Service Water (CCSW) system [BI] was aligned to supply cooling water to the Control Room Emergency Ventilation Air Conditioning (CREVAC) system [VI]. With the bus potential fuses removed, the CCSW system would not have been capable of providing cooling water flow to the CREVAC system.

Due to the 'B' Reactor Protection System [JC] Bus being powered from its reserve supply at the time the fuses were removed, the reactor building ventilation system [VA] isolated and the 'B' Standby Gas Treatment System [BH] system started.

The Bus 23 potential fuse drawer was reclosed and the plant systems were restored to their previous configuration.

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.

C. Cause of Event:

A subsequent investigation revealed that this condition was the result of personnel error. The maintenance technician did not utilize human error prevention tools to ensure that proper verification was completed prior to opening the Bus 23 potential fuse compartment.

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NARRATIVE

D. Safety Analysis:

The safety significance of this condition is low. The fuses were removed for approximately seven seconds. The Control Room Emergency Ventilation system is required to be initiated within forty minutes following an accident. Due to short duration of the inoperability, the health and safety of the public and plant employees were not compromised as a result of this condition.

E. Corrective Actions:

The Bus 23 potential fuse drawer was reclosed and plant systems were restored to the previous configuration.

Electrical Maintenance had a stand down to discuss the event and the consequences of taking actions in the plant without proper guidance with all Electrical Maintenance first line supervisors and craft.

Personnel involved were coached.

Additionally, an evaluation of the implementation of robust barriers for bus pot fuse compartments is being performed.

F. Previous Occurrences:

A review of Dresden Licensee Event Reports (LERs) for the last three years revealed the following reportable condition:

- LER 237/2011-001-00, Loss of Containment Cooling Service Water System due to Stop Log Installation

The corrective actions from the above Licensee Event Report would not have prevented the current event.

G. Component Failure Data:

Not Applicable