

LICENSEE EVENT REPORT

CONTROL BLOCK: _____ ①

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 I L D R S 3 ② 0 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 CAT 58

CON'T
 01 REPORT SOURCE L ⑥ 0 5 0 0 0 2 4 9 ⑦ 0 7 0 6 7 9 ⑧ 0 8 0 3 7 9 ⑨
7 8 DOCKET NUMBER 65 66 67 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

02 During steady unit operation, primary containment vacuum relief and isolation valve
 03 AO-3-1601-20B was found to be open and inoperable. Since redundant check valve
 04 3-1601-31B was operable and closed maintaining primary containment integrity, this
 05 event has minimal safety significance. This is the first event of this type,
 06 although errors in properly identifying equipment have occurred infrequently.
 07 _____
 08 _____
7 8 9

09 SYSTEM CODE S A ⑪ CAUSE CODE A ⑫ CAUSE SUBCODE C ⑬ COMPONENT CODE V A L V O P ⑭ COMP. SUBCODE E ⑮ VALVE SUBCODE Z ⑯
7 8 9

⑰ LER/RO REPORT NUMBER 7 9 ⑱ SEQUENTIAL REPORT NO. 0 1 8 ⑲ OCCURRENCE CODE ⑲ REPORT TYPE L ⑳ REVISION NO. 0
7 8 9

ACTION TAKEN H ⑳ FUTURE ACTION X ㉑ EFFECT ON PLANT Z ㉒ SHUTDOWN METHOD Z ㉓ HOURS 0 0 0 ㉔ ATTACHMENT SUBMITTED Y ㉕ NPRD-4 FORM SUB. N ㉖ PRIME COMP. SUPPLIER N ㉗ COMPONENT MANUFACTURER V 0 9 5 ㉘
33 34 35 36 37 38 39 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ⑳

10 Electricians incorrectly identified 1601-20B valve as 1601-56, which needed repairs,
 11 and began repairs on -20B valve. Operator observed valve out of position, and -20B
 12 valve was returned to normal. Equipment tags on valves in area will be improved.
 13 Improved electrical design to permit operators to take valve O.O.S. will be investi-
 14 gated.
7 8 9

15 FACILITY STATUS E ㉚ % POWER 0 9 7 ㉛ OTHER STATUS NA ㉜ METHOD OF DISCOVERY A ㉝ DISCOVERY DESCRIPTION Operator observation ㉞
7 8 9 10 11 12 13 14 15 16 17

16 ACTIVITY CONTENT Z ㉟ AMOUNT OF ACTIVITY NA ㊱ LOCATION OF RELEASE NA ㊲
7 8 9 10 11 12 13 14 15 16 17

17 PERSONNEL EXPOSURES NUMBER 0 0 0 ㊲ TYPE Z ㊳ DESCRIPTION NA ㊴
7 8 9 10 11 12 13 14 15 16 17

18 PERSONNEL INJURIES NUMBER 0 0 0 ㊴ DESCRIPTION NA ㊵
7 8 9 10 11 12 13 14 15 16 17

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z ㊶ DESCRIPTION NA ㊷
7 8 9 10 11 12 13 14 15 16 17

20 PUBLICITY ISSUED N ㊸ DESCRIPTION NA ㊹
7 8 9 10 11 12 13 14 15 16 17

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ATTACHMENT TO LICENSEE EVENT REPORT 70-18/03L-0

COMMONWEALTH EDISON COMPANY (CWE)

DRESDEN UNIT-3 (ILDRS-3)

DOCKET #050-249

The electricians were to replace the solenoid valve on the AO 3-1601-56 valve. Because the design of the electrical feed to the solenoid valve does not have an individual fused feed, it is not possible for the shift operator establishing the equipment outage to de-energize the solenoid for only the -56 valve. The wires feeding these solenoid valves have to be cut by the electricians, while energized, prior to maintenance.

The air supply isolation valves for the -20B and -56 valves are physically located next to the -20B valve. The electricians went to the area of the valves and saw the out-of-service card on the isolation valve for the air supply to the operator of the -56 valve and inadvertently identified the 1601-20B valve as the 1601-56 valve. The electricians cut the electrical feed to the solenoid of the -20B valve, which was now de-energized and failed open as designed. Thinking that this was normal, no questions were asked by the electricians, who proceeded to loosen the air lines to the -20B solenoid valve. The Control Room-Operator, seeing a torus-to-reactor building vacuum breaker out of position dispatched an operator to investigate. The operator found the electricians at the -20B valve and told them of their mistake. The valve was O.O.S. for about 1 hour.

The electricians reconnected the electrical feed to the AO-1601-20B valve and the valve was returned to its normally closed position.

This event was investigated by a station professionalism committee. Although the report of their findings has not yet been approved, a principal recommendation of the committee will be to improve the labelling of the valves in the area. The valve labels will be upgraded as a part of the station's continuing program to relabel valves. A second major recommendation will be to modify the electrical feed to provide individual fuses for containment vent valves, so as to permit operating shift personnel to complete any equipment outage required for maintenance. This modification will be referred to the Station Nuclear Engineering Department for consideration.

(Other Applicable Information)

At approximately 10:30, AO-3-1601-20B was noticed to have an open indication. An operator was dispatched to determine what was wrong after the valve would not operate from the control room. The operator reported electricians working in the area, using an equipment outage for AO-3-1601-56. The electricians were to lift the electrical leads for the -56 valve, but removed the wrong leads and caused the -20B valve to open. They noticed air blowing from the 20B valve and closed the air supply to that valve. The operator told the electricians that they were on the wrong valve, and they put the leads back. The operator opened the air supply to the 20B which went closed, at about 10:45. The valve was inoperable for about 1 hour as determined by the high radiation log of entry and exit times.

The check valve in the line held closed with the torus at a pressure of +.03 psig.