



Commonwealth Edison

Dresden Nuclear Power Station

R.R. #1

Morris, Illinois 60450


Telephone 815/942-2920

July 16, 1991

EDE Ltr: # 91-435

U.S. Nuclear Regulatory Commission
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Licensee Event Report # 91-013, Docket # 050237 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73 (A)(2)(v)(c).


E. D. Eenigenburg
Station Manager
Dresden Nuclear Power Station

EDE;RW:dwh

Enclosure

cc: A. Bert Davis, Regional Administrator, Region III
File/DVR
File/Numerical

ZDVR/263

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LICENSEE EVENT REPORT (LE

Form Rev 2.0

Facility Name (1) Dresden Nuclear Power Station, Unit 2										Docket Number (2) 0 5 0 0 0 2 3 7				Page (3) 1 of 0 4	
Title (4) Potential Degradation of Secondary Containment Involving Reactor Building Trackway Doors Due to Personnel Error															

Event Date (5)			LER Number (6)				Report Date (7)			Other Facilities Involved (8)	
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)	
0 6	2 4	9 1	9 1	0 1 3	0 0	0 7	1 6	9 1	Dresden Unit 3	0 5 0 0 0 2 4 9	
										N/A	

OPERATING MODE (9) POWER LEVEL (10) 0 7 0		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)																				
		<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(vii)(c)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	<input type="checkbox"/> 50.73(a)(2)(x)	<input type="checkbox"/> 73.71(b)	<input type="checkbox"/> 73.71(c)	<input type="checkbox"/> Other (Specify in Abstract below and in Text)

LICENSEE CONTACT FOR THIS LER (12)											
Name Jeffrey Boyar, Regulatory Assurance Engineer								TELEPHONE NUMBER AREA CODE 8 1 5 9 4 2 - 2 19 2 10			
Ext. 2707											

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)										Expected Submission Date (15)		Month	Day	Year
<input checked="" type="checkbox"/> Yes (If yes, complete EXPECTED SUBMISSION DATE)										<input type="checkbox"/> NO		1	0	0 1 9 1

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

At 1400 hours on June 24, 1991 with Unit 2 and Unit 3 at approximately 70% power, an NRC Inspector discovered the Unit 2 reactor building trackway inner door open with no monitor in attendance, contrary to an administrative procedure governing its use. The inner door had been left unattended since 0845 hours. The next day, June 25, 1991, the NRC Inspector noticed a seal on the lower portion of the outer door was not properly closed. Investigation revealed that this lack of proper sealing on the outer door had existed during the incident of the previous day. This constituted a potential degradation of secondary containment integrity. The cause of the event was attributed to personnel error on the part of a Mechanic who failed to read the posted procedure governing use of the trackway doors and a Work Analyst who changed the scope of a previous work request utilized to install the outer door sealing mechanism. The personnel involved in the event were counselled and a revision is being made to the work request procedure. A secondary containment leak rate test will also be performed to determine if this condition would have violated reactor building differential pressure requirements under reactor building ventilation isolation conditions. The safety significance was minimal because proper reactor building differential pressure was maintained by the reactor building ventilation system and operator action could have been taken to close the inner door if required. A previous event involving inadequate control of secondary containment interlocks is reported by LER 88-018/050249.

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TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

Discussions between the Technical Staff engineer and the Work Analyst during the scope change of the repair work may have contributed to the Work Analyst's decision because inadequate discussion of program requirements for the implementation of the change in design occurred.

Quality Control (QC) and Nuclear Quality Programs (NQP) reviews of the work request failed to discover the error of not applying the Minor Plant Change Program to the work request; thus, inadequate review by QC and NQP also contributed to the event. The Technical Staff personnel involved also did not adequately investigate/follow up to insure that adequate controls were in place or proper reviews performed.

D. SAFETY ANALYSIS OF EVENT:

Technical Specification 4.7.C.1.a requires performance of a secondary containment leak rate test (SCLRT) at each refuel outage prior to refueling in order to demonstrate that one train of the Standby Gas Treatment (SBGT) (BH) system can maintain at least 0.25 inches of water differential pressure in the reactor building with respect to the outside atmosphere. The SCLRT is performed with the Reactor Building Ventilation system (RBVS) (VA) isolated and also includes separate tests of the inner and outer trackway doors. Satisfactory integrity of the outer trackway door was thus demonstrated in September, 1990 with the modified lower seal configuration properly lowered. Satisfactory integrity of the inner trackway door was also demonstrated at that time. During the incident described in this report, the RBVS was operating and maintaining a reactor building differential pressure greater than 0.25 inches of water. If reactor building differential pressure had become unsatisfactory (i.e. during postulated accident conditions resulting in isolation of RBVS and start of SBGT), Operations Shift Supervision would have ordered closure of the inner trackway door in accordance with Control Room annunciator response procedures. These factors would have insured adequate reactor building differential pressure to inhibit exfiltration of the reactor building atmosphere to the outside environment. An SCLRT is also planned to test the as-found (improper lower seal gap) configuration. The results of this special test will be provided in a supplemental report.

E. CORRECTIVE ACTIONS:

- Maintenance personnel involved will be counseled by the Asst. Supt. Maintenance regarding procedure adherence. This item will be completed by July 30, 1991 (237-200-91-11101).
- A Temporary Procedure Change (TPC) has been issued against DAP 13-3 to provide instructions for closing the seal of the outer trackway door.
- A sign has been fabricated to instruct personnel on the proper method of closing the outer trackway door. This sign will be incorporated into one all-inclusive sign for the trackway doors. This item will be installed by July 31, 1991 (237-200-91-11102).
- Mechanical Maintenance, with support from the Technical Staff, will install a new mechanical actuator for the lower seal. This work will be performed in accordance with the Minor Plant Change Program and will be completed prior to the next secondary containment leak rate test (SCLRT) (required prior to the upcoming Unit 3 refuel outage) (237-200-91-11103).
- A memo will be issued to all Licensed Operations personnel on management's expectations regarding the need to ascertain the knowledge level of personnel receiving keys. This memo will be issued by an Operating Engineer by August 1, 1991 (237-200-91-11104).

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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6. A test of secondary containment integrity will be performed with the inner door open and the outer door seal in the raised position. This SCLRT will be performed by the Technical Staff and will be completed prior to the upcoming Unit 3 refuel outage (237-200-91-11105).
7. Entry into and exit from the trackway doors will be incorporated into a station tailgate meeting session. The requirement for logging entry and exit in the center desk log will be emphasized. This tailgate will also discuss posted procedures and provide a listing of posted procedures. The presentation material will be written by the Mechanics involved in the event and will be completed by August 1, 1991 (237-200-91-11106).
8. DAP 15-6, "Preparation and Control of Work Requests" will be revised by the Maintenance Staff to clarify the requirements for control of work scope changes. This item will be completed by February, 1992 (237-200-91-11107).
9. Work Analysts will be trained on the enhancements to be incorporated into DAP 15-6. This training will be accomplished in a tailgate meeting session with the Work Analysts. This item will be completed by August 31, 1991 (237-200-91-11108).
10. The Technical Staff, QC and NQP will review this event to heighten the awareness of the need to review work requests for applicablity of the Minor Plant Change Program when required by a change in a work request's scope. This review will be performed at a tailgate meeting session by August 31, 1991 (237-200-91-11109).
11. Site Nuclear Engineering (NED) will perform a design review of the installed seal configuration to verify that current design codes and standards are met. This item will be completed by August 31, 1991 (237-200-91-11110).

F. PREVIOUS OCCURENCES:

LER/Docket Numbers Title

88-018-0 Potential Violation of Secondary Containment Due to Management Deficiency

The Unit 3 reactor building material interlock inner door was left open and unattended. This was a potential violation of secondary containment integrity because the inner door was not opened during the secondary containment leak rate test performed prior to a previous refuel outage. The safety significance was minimal as the Unit 3 reactor material interlock outer door was locked closed and an adequate reactor building to atmosphere differential pressure was maintained. Corrective actions included improvements to an Administrative procedure concerning use of the Unit 3 Reactor Building material interlock door, labelling improvements, review of the event with contractor personnel and implementation of SCLRT procedure improvements requiring challenge to the outer Unit 3 reactor building material interlock structure and the outer Unit 2 reactor building trackway interlock door. A special SCLRT was also performed at that time, incorporating these improvements. It should be noted that this test demonstrated proper intergrity of the Unit 2 reactor building trackway outer door, and as such no special controls concerning monitoring of the Unit 2 reactor building trackway inner door were required at that time. Review of the current event concluded that the administrative requirement for continuous monitoring of the Unit 2 reactor building material interlock inner door when open had been implemented subsequent to the 1988 event.

G. COMPONENT FAILURE DATA:

This event did not involve component failure. Therefore, this section is not applicable.