



Commonwealth Edison

Dresden Nuclear Power Station
R.R. #1
Morris, Illinois 60450
Telephone 815/942-2920

July 24, 1991

EDE LTR #91-453

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Licensee Event Report #91-004, Docket #050249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73(a)(2)(iv).

E. D. Eenigenburg
Station Manager
Dresden Nuclear Power Station

EDE/dwh

Enclosure

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

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Dresden Nuclear Power Station, Unit 3										Docket Number (2) 0 5 0 0 0 2 4 9				Page (3) 1 of 0 3						
Title (4) Unplanned SBGTS Auto-start During Area Radiation Monitor Calibration 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 7	0 8	9 1	9 1		0 0 4		0 0	0 7	2 4	9 1	Dresden Unit 2			0 5 0 0 0 2 3 7						
											N/A									
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)																	
POWER LEVEL (10) 0 6 2			20.402(b)					20.405(c)					<input checked="" type="checkbox"/> 50.73(a)(2)(iv)					73.71(b)		
			20.405(a)(1)(i)					50.36(c)(1)					50.73(a)(2)(v)					73.71(c)		
			20.405(a)(1)(ii)					50.36(c)(2)					50.73(a)(2)(vii)					Other (Specify		
			20.405(a)(1)(iii)					50.73(a)(2)(i)					50.73(a)(2)(viii)(A)					in Abstract		
			20.405(a)(1)(iv)					50.73(a)(2)(ii)					50.73(a)(2)(viii)(B)					below and in		
			20.405(a)(1)(v)					50.73(a)(2)(iii)					50.73(a)(2)(x)					Text)		
LICENSEE CONTACT FOR THIS LER (12)																				
Name Louis M. Kline										TELEPHONE NUMBER										
Regulatory Assurance										Ext. 2709										
										AREA CODE 8 1 5 9 4 2 - 2 9 2 0										
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)								
Yes (If yes, complete EXPECTED SUBMISSION DATE)												X NO								
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																				

On July 8, 1991 at 0810 hours with Unit 2 at 50% power and Unit 3 at 62% power, the Instrument Maintenance Department was conducting Dresden Instrument Surveillance (DIS) 1800-2, Area Radiation Monitor Calibration. An Instrument Mechanic (IM) had reached a portion of the procedure which required the disconnecting of a cable from the back of an Isolation Condenser Area Radiation Monitor Indicator Trip Unit which is located inside Control Room Panel 903-11. However, the IM inadvertently disconnected a cable supplying the Reactor Building Fuel Pool Channel A Process Radiation Monitor Indicator Trip Unit which is located inside an adjacent Control Room Panel. When the incorrect cable was disconnected the Standby Gas Treatment System automatically started and the Unit 2 and Unit 3 Reactor Building Ventilation Systems isolated. Prompt investigation by Control Room personnel identified the error and the affected systems were returned to normal. This event had no affect on normal power operation and the automatic actuations that occurred were as expected when challenged by the spurious Fuel Pool Area Radiation signals. A previous event involving an unplanned Engineered Safety Feature actuation due to personnel error was reported by LER 90-010/050237.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		Year	///	Sequential Number	///	Revision Number				
Dresden Nuclear Power Station	0 5 0 0 0 2 4 9	9 1	-	0 0 4	-	0 0	0 2	OF	0 3	

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

PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2527 MWt rated core thermal power

Nuclear Tracking System (NTS) tracking code numbers are identified in the text as (XXX-XXX-XX-XXXXX)

EVENT IDENTIFICATION:

Unplanned Standby Gas Treatment System (SBGTS) Auto-Start [BH] During Area Radiation Monitor [IL] Calibration Due to Personnel Error

A. CONDITIONS PRIOR TO EVENT:

Unit(s): 2(3)

Event Date: July 8, 1991

Event Time: 0810 Hours

Reactor Mode(s): N(N)

Mode Name(s): Run(Run)

Power Level(s): 50%(62%)

Reactor Coolant System (RCS) Pressure(s): 945 (1011) psig

B. DESCRIPTION OF EVENT:

On July 8, 1991 at 0810 hours with Unit 2 at 50% power and Unit 3 at 62% power the Instrument Maintenance Department (IMD) was in the process of conducting Dresden Instrument Surveillance (DIS) 1800-2, Area Radiation Monitor Calibration. The Instrument Mechanic (IM) who was conducting the surveillance test had progressed to a part of the procedure that required the disconnection of a cable supplying the Isolation Condenser [BL] Area Radiation Monitor Indicator Trip Unit. The IM located the correct Control Room Panel (903-11) where the cable was located, located the correct cable and noted that it was the cable in the upper row of cables and was the one on the extreme left. The IM also noted that where the cable connector connected to the chassis, the chassis was labeled with the location of J-4.

The IM had located the correct cable by properly following the surveillance work package; however, upon placing the work package on the floor to free her hands so that she could disconnect the cable, she unconsciously took a step to the left. This resulted in inadvertently entering adjacent Control Room Panel 903-10, which looks almost identical to Control Room Panel 903-11. The IM then disconnected the cable that was in the upper row of cables and on the extreme left (where this cable connected to the chassis, the chassis was labeled with a location of J-4). This cable supplied an Indicator Trip Unit for the Reactor Building Fuel Pool Area Channel A Process Radiation Monitor.

When the IM disconnected the cable on the Reactor Building Fuel Pool Channel A Process Radiation Monitor Indicator Trip Unit an Upscale Signal was generated to start the Standby Gas Treatment System (SBGTS) and tripped the Unit 2 and Unit 3 Reactor Building Ventilation Systems. The logic associated with this trip unit is one upscale or two downscals to generate the actuation signal.

C. APPARENT CAUSE OF EVENT:

This event is being reported in accordance with Title 10 of the Code of Federal Regulations Part 50 Section 73(a)(2)(iv), which requires the reporting of any event that results in manual or automatic actuation of any Engineered Safety Feature.

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

The cause of this event was Personnel Error on the part of the IM for not adequately self-checking to ensure that she was disconnecting the correct cable.

When the incorrect cable was disconnected the SBGTS automatically started and the Unit 2 and Unit 3 Reactor Building Ventilation systems automatically isolated.

D. SAFETY ANALYSIS OF EVENT:

Automatic start of the SBGTS and isolation of the Reactor Building Ventilation systems had no affect on normal power operation. Review of logic configuration confirmed that the error satisfied the conditions for these automatic actuations.

E. CORRECTIVE ACTIONS:

The immediate corrective action was to reconnect the cable for the Reactor Building Fuel Pool Channel A Indicator Trip Unit. Then the Unit 2 and Unit 3 Reactor Building Ventilation was reset and restored to its normal configuration and the SBGTS was secured.

The IM involved in the event will be counselled by Instrument Maintenance Supervision to reinforce the need to always self-check to ensure that the correct component has been located prior to working on the component. Also this event is to be reviewed with all IMs and Instrument Supervisors to clarify management expectations concerning self-checking. This will be completed by July 26, 1991 (249-200-91-04301).

F. PREVIOUS OCCURENCES:

LER Number	Title
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90-003/050249	Partial Group II Primary Containment Isolation and Standby Gas Treatment Initiation Due to Personnel Error.
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The Unit 3 Nuclear Station Operator (NSO) was in process of performing Outage Request III-460. The Outage Request was submitted by the Electrical Maintenance Department for the removal of fuse 595-718 to allow replacement of a broken terminal point at NN-104 on panel 903-4. However, the NSO removed fuse 595-718 and an unplanned partial Primary Containment Group II Isolation [JM] occurred, initiating an automatic actuation of the SBGTS and isolation of Reactor Building Ventilation. The investigation concluded the incorrect fuse was specified on Outage Request III-460 due to the wrong fuse being identified from the electrical print and then transferred to the Outage Request.

90-010/050237	2B Core Spray [BM] Pump Automatic Start due to Inadvertent Personnel Error.
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Maintenance activities were under way on the Unit 2 Diesel Generator [EK] cubicle on electrical Bus 24-1. The Stationary Auxiliary Switch, which was being replaced, contains contacts which bypass the diesel generator sequencing timer and allows the 2B Core Spray pump to automatically start upon initiation signal when the normal source of AC power is supplying the bus. It is hypothesized that the electrician working on the Stationary Auxiliary Switch replacement inadvertently caused a ground which caused 2B Core Spray Pump to start.

G. COMPONENT FAILURE DATA:

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