



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

9108050295 910724
PDR ADDCK 05000249
S PDR

TRIP
||

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Dresden Nuclear Power Station, Unit 3 Docket Number (2) 0 15 10 10 10 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	9	1	0	0	0	7	2	4	9	Dresden Unit 2	0 15 10 10 10 2 3 7
										N/A		

OPERATING MODE (9) N

POWER LEVEL (10) 0 6 2

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(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> Other (Specify in Abstract below and in Text)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name Louis M. Kline Telephone Number AREA CODE 8 1 5 9 4 2 -2 9 2 10
 Regulatory Assurance Ext. 2709

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)

[Yes (If yes, complete EXPECTED SUBMISSION DATE)] X | NO Expected Submission Date (15)

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.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						Page (3)		
		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 3	OF	0 3	

TEXT Energy Industry Identification System (EIS) 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 effect 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

90-003/050249 Partial Group II Primary Containment Isolation and Standby Gas Treatment Initiation Due to Personnel Error.

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.

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.