



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

February 6, 1992

CWS LTR #92-070

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

Licensee Event Report 92-03, Docket 050249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73 (a)(2)(iv).

L. F. Gerner for 2/6/92

Charles W. Schroeder
Station Manager
Dresden Nuclear Power Station

CWS/slp

Enclosure

cc: A. Bert Davis, Regional Administrator, Region III
NRC Resident Inspector's Office
File/NRC
File/Numerical

(ZDVR/469)

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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) 0 1 of 0 4		
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Title (4) Unexpected Partial Group II Containment Isolation During Surveillance Testing
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)		
01	15	92	92	0 0 13	0 0	02	06	92	N/A				
										N/A			

OPERATING MODE (9) N

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

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 in Abstract below and in Text)
20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

POWER LEVEL (10) 0 | 0 | 0

LICENSEE CONTACT FOR THIS LER (12)

Name P. K. Garrett Regulatory Assurance Engineer	Ext. 2713	TELEPHONE NUMBER AREA CODE 8 1 5 9 4 2 - 2 9 2 0
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

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

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

At 1317 hours on January 15, 1992, with Unit 3 shut down for a refuel outage, an unplanned partial Primary Containment Group II isolation occurred while Electricians were performing a surveillance on Main Steam Isolation Valve (MSIV) electrical components. One of the Electricians determined a wiring connection in accordance with the procedure; however, this unexpectedly interrupted control power to several seal-in relays causing certain Group II isolation valves to close. No Group II isolation alarm was received. The Electricians completed the testing on MSIV 3-203-1D and were then informed by the Unit 3 Operator that a partial isolation had been produced. The root cause of the event was attributed to personnel error on the part of an individual performing a field verification of the procedure prior to its use. Corrective actions included a field verification of the surveillance, a work request was initiated to correct the wiring, and revision to the surveillance procedure. This event had minimal safety significance because there was no effect on the logic function. A previous related event was reported by LER 90-22/050237.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

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 2	-	0 0 3	-	0 0	0 2	0 f	0 4	

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 (249-200-92-006XX)

EVENT IDENTIFICATION:

Unexpected Partial Group II Primary Containment Isolation [JM] During Surveillance Testing Due to Personnel Error

A. CONDITIONS PRIOR TO EVENT:

Unit: 3 Event Date: January 15, 1992 Event Time: 1317 Hours

Reactor Mode: N Mode Name: Shutdown Power Level: 0%

Reactor Coolant System (RCS) Pressure: 0 psig

B. DESCRIPTION OF EVENT:

On January 15, 1992, while Unit 3 was shut down for a refuel outage, Electricians were in the Main Control Room performing Dresden Electrical Surveillance (DES) 0200-39, Main Steam [SB] Isolation Valve (MSIV)-Electrical Maintenance. The surveillance called for performing a resistance and meggering check of the solenoid valves for MSIV 3-203-1D. While performing the surveillance on panel 903-3, a partial Group II Primary Containment Isolation unexpectedly occurred at 1317 hours when the field lead was lifted from terminal AA-50. Although no Group II Isolation alarm was received, 14 of the 44 valves went closed. The Electricians were not aware of the actuation until the test on the 3-203-1D MSIV was complete and were then notified by the Unit 3 Operator of the partial isolation. The wire was then immediately reraled. The Unit 3 Operator reset the isolation and opened the valves involved in the event. The Electricians terminated the surveillance. Operations immediately initiated a preliminary investigation and determined that the event was a direct result of the surveillance in progress, and not the result of an actual Group II Isolation signal.

The investigation revealed that the seal-in relays associated with the valves that closed were de-energized when an electrical connection was inadvertently determined in panel 903-3. When the solenoid field wiring was removed from wire terminals AA-50 and AA-51 per DES 0200-39, another connection had also been inadvertently lifted at AA-50 due to a discrepancy between the field configuration and the wiring diagram. This connection provides the 120 volt AC neutral power feed to the solenoid valves and control relays of the affected valves. Although the wiring diagram shows the jumper on the component side of terminal block AA, it was actually installed on the field wire side.

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Form Rev 2.0

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						Page (3)		
		Year	///	Sequential	///	Revision	Number		OF	
				Number		Number				
Dresden Nuclear Power Station	0 5 0 0 0 2 4 9	9 2	-	0 0 3	-	0 0	0 3			0 4

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C. APPARENT CAUSE OF EVENT:

This event is reported in accordance with 10CFR50.73(a)(2)(iv), which requires the reporting of any unplanned Engineered Safety Feature (ESF) actuation, because it resulted in the unplanned movement of Primary Containment Isolation valves.

Investigation indicated that a related event had occurred during the previous Dresden Unit 2 refuel outage (refer to LER 90-22/050237) during performance of DES 0200-39. A similar discrepancy between the wiring diagram and field configuration was involved in that event, and corrective actions initiated at that time included a field verification of the procedure on both Dresden Units 2 and 3 in order to insure proper match to the wiring drawings. This activity was completed as required prior to the current Unit 3 refuel outage, and resulted in correction of one discrepancy in panel 903-3. However, the personnel involved with the verification failed to identify/correct the discrepancy on panel 903-3 terminal AA-50, which resulted in the event described in this report. Therefore, this event was attributed to personnel error on the part of the personnel performing the field verification. It should be noted that these wiring discrepancies had no effect on the logic function, and are believed to have occurred at the time of original plant construction.

A contributing cause to this event was a procedural deficiency, in that DES 0200-39 did not account for a possible wiring configuration deficiency. If the workers had checked for dual landings on the terminal, they may have prevented this event by reviewing it with their Supervisor and correcting the jumper prior to proceeding with the surveillance.

D. SAFETY ANALYSIS OF EVENT:

Although certain valves associated with a Primary Containment Group II Isolation unexpectedly closed, these actuations were caused by inadvertent interruption of control power to the seal-in circuitry for the affected valves, and did not in any way affect the ESF logic or the ability of the Group II logic to perform its intended function. Furthermore, primary containment integrity was not required at this time. Therefore, this event had minimal safety significance.

E. CORRECTIVE ACTIONS:

DES 0200-39 was re-reviewed and re-field-verified for both units and then rechecked by the Senior Electrical Maintenance Work Analyst. No similar configuration discrepancy was found for Unit 2. Only the one discrepancy for Unit 3 in Panel 903-3 on terminal AA-50 was found. This action is complete.

The electrical wiring discrepancy will be corrected on Unit 3 panel 903-3 under Work Request (WR) 06082 (249-200-92-0060-1). ~~This WR will be complete prior to Unit 3 startup.~~

This event has been reviewed with the Electrical Maintenance Department personnel to stress the importance of performing effective field verifications of procedures.

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

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The Master Electrician has counseled the individuals involved in the previous field verification.

DES 0200-39 will be updated by the Electrical Maintenance Department to include a precaution that the field side of the AC terminal blocks in the panels in the Control Room shall have no more than one lead per terminal. If there are more than one lead per terminal, the Electricians will notify the Supervisor, and suspend performance of the surveillance until the issue is resolved. This action will be performed by the Electrical Maintenance Department (249-200-92-00602).

F. PREVIOUS OCCURRENCE

LER/Docket Numbers Title

90-22/050237 Unexpected Closure of 11 Containment Isolation Valves During Surveillance Testing Due to Procedure Deficiency

This event involved an unplanned partial Group II Isolation. This occurred during performance of DES 0200-39 on Unit 2. The cause of the event was a wiring configuration deficiency. Corrective actions included a review and field check of DES 0200-39, moving the affected leads and review of the event in a station tailgate meeting.

G. COMPONENT FAILURE DATA:

~~This section is not applicable because this event did not involve component failure.~~