Commonwealth Edison
Dresden Nuclear Power Station
6500 North Dresden Road
Morris, Illinois 60450
Telephone 815/942-2920

July 23, 1993

GFSLTR 93-0023

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

Licensee Event Report 3-93-009, Docket 050249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73 (a)(2)(i)(B).

Gary Spedl 7/28/93
Station Manager
Dresden Station

GFS/slb

Enclosure

cc: J. Martin, Regional Administrator, Region III
NRC Resident Inspector's Office
File/NRC
File/Numerical

090043

IE22

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1)	Docket Number (2)	Page (3)
Dresden Nuclear Power Station, Unit 3	0 5 0 0 0 2 4 9	1 of 0 4

Title (4)

Isolation Valve for Isolation Condenser Initiation Pressure Switch, PS 3-263-53C, Found Closed During Performance of Surveillance DIS 1300-1 Due to Unknown Cause

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 5	1 2	9 3	9 3	0 0 9	0 0	0 7	2 8	9 3	N/A	
									N/A	

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIRMENTS OF 10CFR (Check one or more of the following) (11)											
POWER LEVEL (10)	1 0 0		20.402(b)		20.405(c)		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)	X	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)						

LICENSE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
J. Rivera Ext.3527	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	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)	X NO				

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

At 1920 on May 12, 1993 while performing Sustained High Reactor Pressure Calibration Surveillance (DIS 1300-1), the isolation valve for Isolation Condenser Initiation Pressure Switch (PS 3-263-53C) was found in the closed position in violation of Technical Specification Table 3.2.2 by not having two operable instrumentation channels per trip system. The station event reporting process did not identify the event as reportable to the NRC via an LER. As a result, this LER is not being reported within the 30 day reporting criteria.

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:

Isolation Valve for Isolation Condenser Initiation Pressure Switch, PS 3-263-53C, Found Closed During Performance of Surveillance DIS 1300-1 Due to Unknown Cause

A. CONDITIONS PRIOR TO EVENT:

Unit: 3 Event Date: May 12, 1993 Event Time: 1920

Reactor Mode: R Mode Name: N Power Level: 100

Reactor Coolant System (RCS) Pressure: 1000 psig

B. DESCRIPTION OF EVENT:

While in the process of performing surveillance testing DIS 1300-1 (Sustained High Reactor Pressure Calibration) at 1920 on May 12, 1993 with Unit 3 at 1000 psig, the isolation valve for the 3-263-53C switch was found to be in the closed position . This was the third out of four switches which were to be checked/calibrated. Switches 3-263-53A and 3-263-53B had been checked prior to the 53C switch. The Shift Control Room Engineer (SCRE) was notified by telephone of the situation and it was decided to continue the calibration. Since the switch was already isolated, the calibration was performed and was found to trip in tolerance. The switch was then valved back into the system with no further problems. The event was reported to station management through the event reporting process. The Shift Engineer initially classified the event as reportable per 10 CFR 50.73(a)(2)(i)(B). The event was reviewed via station procedures (Reference NTS# 249-201-93-09700) and reclassified as a Non-Reportable Event. The station uses an Event Screening Committee (ESC) to review events.

Technical Specifications Table 3.2.2 requires that two instrument channels be operable for each trip system. Since switch 3-263-53C was found isolated, the technical specification was not in full compliance; however, the second of two switches (3-263-53A) in the same instrument channel had successfully passed the surveillance testing. Thus, except for approximately one-half hour when the second switch was being tested, it would have provided the necessary initiation signal had it been required to on high reactor pressure. The logic for this trip system consists of 2 channels with 2 instruments in each channel providing a one-out-of-two-twice logic.

On July 1, 1993 at 1600 hours, a Station Regulatory Assurance member noted, after discussion with an NRC resident, that Problem Identification Form (PIF) #249-201-93-09700 had been originally screened by the Shift Engineer on May 12, 1993 to be a reportable event. However, the Event Screening Committee had changed the classification to non-reportable. Upon further review, it has been determined that the event was reportable and that the thirty day reporting time period was exceeded.

C. APPARENT CAUSE OF EVENT:

This report is being submitted in accordance with 10CFR50.73(a)(2)(i)(B) which requires the reporting of any operation or condition prohibited by the plant's Technical Specifications.

The cause of the isolated switch remains indeterminate. The Surveillance which was performed prior to this event was reviewed. The Surveillance requires that the technician return the isolation valve to the open position. It further requires an independent verification to ensure that the valve is open. The surveillance was performed satisfactorily and was signed off accordingly. Further, upon interviewing the independent verifier, he stated that he remembered the incident and that he believed he had performed the required valve verification.

The misclassification of the event's reportability was due to the Event Screening Committee misinterpreting the CECo. Reportability Manual, Section SAF 1.15 "Operation Prohibited by Technical Specifications". The third paragraph on Page 2 of 4 of this section states, "In general, for the purpose of evaluating the reportability of situations found during surveillance tests, it should be assumed that the situation occurred at the time of discovery, unless there is firm evidence to believe otherwise."

The Committee believed that since the cause and time could not be determined, there was no such firm evidence, and that it should be assumed that the mispositioning occurred at the time it was discovered. Subsequent review concluded the probability existed that the 53C switch was inoperable when the 53A switch was calibrated to make the event reportable under 10CFR50.73(a)(2)(i)(B).

D. SAFETY ANALYSIS OF EVENT:

The safety significance of the isolated switch is considered minimal. The isolation condenser was unavailable for approximately one-half hour, the time that it took to check the calibration of the 3-263-53A switch. In light of the fact that the 53A switch was operable in one instrument channel prior to its testing (as well as after its satisfactory test), it and both operable switches in a second instrument channel would have initiated the isolation condenser if required.

The safety significance of the misclassification is negligible although it provides indication that the event review process at the station needs improvement.

E. CORRECTIVE ACTIONS:

Isolation of the pressure switch: The pressure switch event was corrected by re-opening the isolation valve. No further action is required.

Misclassification by the Event Screening Committee: Regulatory Assurance reviewed the event with the Event Screening Committee, and presented the accepted interpretation of Reportability Manual Section SAF 1.15. This LER will be distributed to Training for inclusion in licensed operator required reading.

F. PREVIOUS OCCURRENCES:

LER/Docket Numbers	Title
12-2-93-90/050237	OOS Problem-Mispositioned valve. Valve was found open. Valve had been verified closed when performing an out-of-service operation. Unknown how it was opened.
12-2-92-28/050237	Feedwater heater level controlling transmitter root valve found closed. Source of error could not be determined.

G. COMPONENT FAILURE DATA:

Manufacturer	Nomenclature	Model Number	Mfg. Part Number
Not Applicable			