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

April 5, 1994

GFSLTR 94-0107

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

Licensee Event Report 94-010, Docket 50-249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10CFR50.73(a)(2)(iv).

Sincerely,

Gary F. Spedl
Station Manager
Dresden Station

GFS/JJV:cfq

Enclosure

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

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NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Dresden 3	05000249	1 OF 3

TITLE (4)
Reactor Scram While Unit was Shut Down 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 NAME	DOCKET NUMBER
03	11	94	94	-- 010 --	00	04	08	94	None	
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
POWER LEVEL (10)	000		20.402(b)		20.405(c)	X	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	
			20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in Abstract below and in Text, NRC Form 366A)	
			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)			

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
J. J. Viney Ext. 3526	(815) 942-2920

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 15 single-spaced typewritten lines) (16)

At 2015 on March 11, 1994, a Reactor Scram was received while Instrument Maintenance Department (IMD) was performing Dresden Instrument Surveillance procedure (DIS) 700-4, Intermediate Range Monitor (IRM) surveillance. The Nuclear Station Operator (NSO) reset the scram per Dresden General Procedure (DGP) 2-3 and in attempting to return the Control Room panels to an "as normal" condition as soon as practicable, the NSO placed the Scram Discharge Volume (SDV) Reactor Scram bypass switch back to the "normal" position before the volume had drained down. This resulted in a second scram signal. The first scram signal was spurious due to an IRM spiking, the second scram signal was due to personnel error. The Unit 3 reactor was in refueling outage so consequences of the event are negligible.

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 3 Event Date: March 11, 1994 Event Time: 2015

Reactor Mode: Shutdown Mode Name: Outage Power Level: 0

Reactor Coolant System Pressure: 0 psig

B. DESCRIPTION OF EVENT:

At 2015 on March 11, 1994, a Reactor Scram was received while IMD was performing DIS 700-4, IRM surveillance. The surveillance requires an "IRM Hi Hi" trip signal from an assigned IRM, this gives a half scram to its associated Reactor Protection System (RPS) channel. A spurious signal from a spiking IRM in the opposite channel from the one in test caused a full reactor scram. The NSO reset the scram per DGP 2-3, and in attempting to return the Control Room panels to an "as normal" condition, the NSO placed the SDV reactor scram bypass switch back to normal before the discharge volume had drained down. This resulted in a second scram due to high level in the SDV tank.

The spurious signal received on IRM 13 due to spiking is the result of "noise" from the IRM cabling. The cables are due to be replaced in this outage to prevent the further problem of spurious scrams due to spiking of the IRM's.

C. CAUSE OF EVENT:

This report is being submitted in accordance with 10CFR50.73(a)(2)(iv) which requires the reporting of any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature.

Causal factor; Spiking of IRM's due to faulty cabling.

Type of Inappropriate Action: untimely act; correct action performed too soon.

Behavioral function in which the inappropriate action occurred: checking/verification; operator did not verify discharge volume prior to switch manipulation.

Causal Factor that lead to the inappropriate action: work practices; self checking not applied to ensure intended action is correct before it is performed.
Root cause; Operator error, inattention to detail.

D. SAFETY ANALYSIS:

The purpose of the Scram Discharge Volume (SDV) and the Scram Instrument Volume (SIV) is to receive and contain the water exhausted from all the Control Rod Drives (CRDs) during a Reactor Scram, thereby limiting the loss of water from the Reactor Pressure Vessel. The SDV is comprised of a header piping that runs over the top of the CRD Hydraulic Control Units (HCUs). Each bank of the HCUs directs its water to the SDV piping directly overhead which in turn drains to one of the SIVs. During a SCRAM condition, the SDVs and SIVs fill with reactor coolant due to the displaced water from the overpiston areas and normal leakage

past the CRD mechanism seals. For this event, all the CRDs were already at position "00". No volume of water was present for exhausting from the overpiston area of each CRD to put them in a Scrammed position. Since all the CRDs were at "00" prior to the Scram, the safety significance of this event is considered minimal.

E. CORRECTIVE ACTIONS:

The event was tailgated to all operation crews.

The individual involved in the event self-initiated writing a letter to the Operations Crews describing the event and how intellectual self-check could have prevented the error, so all could learn from the event.

F. PREVIOUS OCCURRENCES:

LER/Docket Number	Title
12-2-93-15/050237	Unit 2 reactor scram, group 2 and group isolation, while shutdown.

G. COMPONENT FAILURE DATA:

Manufacturer	Nomenclature	Model Number	Mfg. Part Number
Not Applicable			