



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

September 20, 1994

EDELTR 94-0028

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

Licensee Event Report 94-025, Docket 50-237 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10CFR50.73(a)(2)(i)(b).

Sincerely,

E. D. Eenigenburg
Unit 2 Station Manager
Dresden Station

EDE/DK: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							
LICENSEE EVENT REPORT (LER)								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.				
FACILITY NAME (1) Dresden Nuclear Power Station, Unit 2/3						DOCKET NUMBER (2) 05000237		PAGE (3) 1 OF 4				
TITLE (4) Continuous Monitoring of 2/3 Chimney Effluent Not Performed Due to SPING Inadvertently Put in Flush Mode.												
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		
08	26	94	94	-- 025 --	00	09	20	94	None			
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)										
N		20.2201(b)		20.2203(a)(3)(i)		50.73(a)(2)(iii)		73.71(b)				
POWER LEVEL (10)		20.2203(a)(1)		20.2203(a)(3)(ii)		50.73(a)(2)(iv)		73.71(c)				
000		20.2203(a)(2)(i)		20.2203(a)(4)		50.73(a)(2)(v)		OTHER				
		20.2203(a)(2)(ii)		50.36(c)(1)		50.73(a)(2)(vii)		(Specify in Abstract below and in Text, NRC Form 366A)				
		20.2203(a)(2)(iii)		50.36(c)(2)		50.73(a)(2)(viii)(A)						
		20.2203(a)(2)(iv)		X 50.73(a)(2)(i)		50.73(a)(2)(viii)(B)						
		20.2203(a)(2)(v)		50.73(a)(2)(ii)		50.73(a)(2)(x)						
LICENSEE CONTACT FOR THIS LER (12)												
NAME David Klingensmith, Radiochemist						TELEPHONE NUMBER (Include Area Code) Ext. 2577 (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)

Continuous monitoring of 2/3 main chimney effluent was not performed due to the Noble Gas Monitor (SPING) inadvertently being put in flush mode. At 1316, 8/26/94 the 2/3 main chimney SPING was inadvertently placed into the flush mode. The incorrect mode was not noticed until 2302, 8/26/94, at which time the system was switched to the G.E. backup system. Technical Specifications Table 3.2.5 states that grab samples must be obtained every 8 hours when the SPING is inoperable. The grab sample was obtained approximately 12 hours after the SPING was put into the wrong mode. Some difficulties were also encountered when switching over from the SPING to the G.E. backup system. Both units were shutdown during this event and samples before and after were at normal levels. The safety impact was minimal.

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

EVENT IDENTIFICATION:

Continuous Monitoring of 2/3 Chimney Effluent Not Performed Due to SPING Inadvertently Put in Flush Mode.

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 2 Event Date: 08/26/94 Event Time: 23:02
 Reactor Mode: N Mode Name: Refuel Power Level: 0%
 Reactor Coolant System Pressure: 0 psig

B. DESCRIPTION OF EVENT:

On August 26, 1994, at 2302 hours, with both units 2 and 3 shutdown and at 0 psig reactor coolant system pressure, the center desk NSO found the 2/3 main chimney SPING channels 1,3,4,5,7,8,and 9 in "flush" mode. A chemistry technician was dispatched to the SPING to investigate and correct the problem. Initial attempts to correct the problem and return the SPING to service failed and an operator was called to switch to the G.E. Backup system. After numerous pump trips, the G.E. system was finally placed in service at 0125 8/27/94. A Noble gas sample was obtained per Tech. Spec. Table 3.2.5 and the results showed no observed Noble gas activity. An Emergency Notification System phone call was made to the NRC at 0145 8/27/94 by the Shift Control Room Engineer.

A health physics supervisor removed the SPING from flush mode and with a chemistry technician, placed the SPING back in service at 0330 8/27/94. The particulate filter that was removed from the G.E. system for analysis had a hole in it, permitting particulates to bypass the filter and be captured in the charcoal cartridge. A check of the printed records from the 923-7 panel indicated the SPING had been on flush from 1316, 8/26/94, the approximate time a chemistry technician had changed the particulate and charcoal cartridge filters as scheduled by a weekly surveillance. The station was without main chimney offsite dose assessment monitoring for approximately 12 hours.

C. 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 plants Technical Specifications.

As stated earlier, the initial cause for the event was the apparently inadvertent placement of the SPING into the flush mode by the chemistry technician during a routine sample change. This was done by unknowingly depressing the "flush" switch on the SPING control panel. All local indications checked while following the chemistry procedure (DCP 2213-01 checklist 3) for changing the sample filters were as expected, and no indications that the SPING was placed in flush mode were observed. It was only when the center desk NSO read the 923-7 panel that the flush mode was detected.

The pump trips and difficulties of placing the G.E. system in service were caused by deficiencies and ambiguities in the operations procedure (DOP 1700-

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11). There is a question as to which valve(s) need to be opened and throttled and at what speed to prevent the flow oscillations and the associated pump trips.

The hole in the G.E. system particulate filter was apparently caused by the flow/pressure oscillations as mentioned above. The filter paper is made from a material that is easily crumbled and broken. The pressure oscillations apparently flexed and then broke a hole in the paper.

Three Problem Identification Forms (PIF's, DAP Form 02-27A) addressing the above problems were submitted to the Shift Engineer on 8/26 and 8/27.

D. SAFETY ANALYSIS:

The 2/3 main chimney SPING and its G.E. system backup, monitors Noble gas, particulate, and Iodine isotopes being released into the environment. For the period from 1316 8/26/94 until 0125 8/27/94 the station was without this capability to monitor the offsite dose assessment from the 2/3 main chimney. The samples obtained before the SPING was placed on flush, the Noble gas grab sample, the samples taken from the G.E. system, and the sample collected after putting the SPING back in service, all were within the "normal" range of values. Both nuclear units were in shutdown mode and no abnormal occurrences were noted during the period with no monitoring. The safety significance of this event was minimal.

E. CORRECTIVE ACTIONS:

Immediate corrective actions were to switch to the G.E. system. When this was found to be difficult, additional personnel were summoned to correct the initial problem with the SPING and return it to service. The SPING was returned to service approximately 4.5 hours after the first indications of a problem. The charcoal cartridge downstream of the G.E. system particulate filter was analyzed to provide accurate quantification of the particulate matter that was able to flow by the broken filter.

The chemistry procedure (DCP 2213-01) is being revised so that the checklist will include an initialed step and verification that the SPING was found before changing the samples and returned to service in the correct operating mode. This involves checking an additional channel on the SPING readout. The verification will prevent any recurrence of this kind of event.

The operations procedure (DOP 1700-11) for switching from the SPING to the G.E. system is being incorporated into the chemistry procedure for changing the samples and startup of the G.E. system (DCP 2213-01). The enhanced, resulting procedure will provide clear instruction on the method for switching systems, preventing flow oscillations, and will minimize the number of departments involved in the switchover.

The Chemistry technician who inadvertently placed the SPING into flush node has recognized his mistake and its potential consequences and will not allow it to recur.

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F. PREVIOUS OCCURRENCES:

LER/Docket Number	Title
94-019/05000237	2/3 Chimney Grab Sample not obtained within required time frame.
92-046/05000237	Reactor Building Vent SPING missed Iodine sample, surveillance with SPING inoperable, due to procedure deficiency.

G. COMPONENT FAILURE DATA:

Not Applicable