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

October 20, 1994

EDELTR 94-0044

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

Licensee Event Report 94-027, Docket 50-237 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10CFR50.73(a)(2)(vii).

Sincerely,

E. D. Eenigenburg Unit 2 Station Manager Dresden Station

EDE/JJV:cfq

Enclosure

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

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NRC FOR	M 366			<u></u> .	U.S.	NUCLEAR	REGULATO	RY COMM	ISSION			APPROVED BY EXPI	APPROVED BY ONB NO. 3150-0104 EXPIRES 5/31/95			
	LICINSEE 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							DOCKET NUMBER (2) 05000237			PAGE (3) 1 OF 4						
TITLE (4	6) Both	RVWI	IS Lo	ops Inad	lverta	ntly Re	emoved	From	Serv	ice I	Du	e to Perso	onnel E	rro	or	
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On September 22, 1994 at 1830, with Unit 2 in cold shutdown with the Reactor Vessel flooded to the Main Steam lines, it was discovered that the instrumentation for Reactor Low Low Water Level Emergency Core Cooling System (ECCS) initiation was valved out for both trip systems. This rendered auto initiation of ECCS on Reactor Low Low Water Level inoperable for approximately eight hours. Technical Specification limits were not exceeded during this lineup due to the cold shutdown condition of the Reactor. Alternate level instrumentation was available for monitoring Reactor Vessel level, but auto initiation of ECCS was not operable. Root Cause of the event is inadequate tracking of Technical Specification requirements by Operations Personnel and lack of consideration of systems affected by Reactor Vessel Water Level Instrumentation (RVWLIS) by Operations personnel.

NRC FORM 366A (5-92)	U.S. NUCLEAR	REGULATORY COMMISSION	APPROVED BY ONB NO. 3150-0104 EXPIRES 5/31/95					
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

EVENT IDENTIFICATION:

Both RVWLIS Loops Inadvertantly Removed From Service Due to Personnel Error

PLANT CONDITIONS PRIOR TO EVENT:

Unit: 2		Event Date:	09/22/94	Event	Time:	Approx,	1500
Reactor Mode:	N.	Mode Name:	Cold Shutdown	Power	Level:	0%	•
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Reactor Coolant System Pressure: 0 psig

DESCRIPTION OF EVENT:

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On September 22, 1994 at 1830, with the Dresden Unit 2 Reactor in cold shutdown the "B" loop of RVWLIS was taken Out Of Service (OOS) while the "A" loop was already OOS.

The "A" loop of instrumentation had been OOS for a number of days preceding the event. Work for the RVWLIS modification on "A" loop had been completed. Operations was requested to return the "A" loop to service and remove the "B" loop from service to complete the modification installation. This return to service on the "A" loop was passed through two shifts to be returned to service but due to other priorities did not get accomplished. During the morning of September 22, the Unit 3 Shift Manager was made aware of schedule delays to construction because the "B" loop had not been removed from service. He instructed the Unit 2 Field Supervisor to take the "B" loop OOS. The Unit 2 Field Supervisor had been told at shift change that the "A" loop had to be returned to service, but did not remember this when told of the schedule delays that "B" loop was creating. The Unit 2 Field Supervisor did not think of the scope of the OOS as affecting other than level indication and coordinated the work personally with the Unit 2 Nuclear Station Operator (NSO) and Unit 2 Equipment Attendant (EA) bypassing the Unit 2 Unit Supervisor. The Unit 2 NSO also did not realize the work scope of the OOS and knowing that other level indication was available did not question the OOS. This condition was corrected by the following shift when they recognized both "A" and "B" loops were valved OOS by restoring "A" loop to operable service.

Personnel involved in this event recognized and acknowledged how their performance contributed to this incident.

CAUSE OF EVENT:

This report is submitted in accordance with Title 10 of the Code of Federal Regulation Part 50 Section 73 (A) (2) (vii), which states that any event that results in two independent trains or channels to become inoperable in a single system designed to mitigate the consequences of an accident must be reported.

Contributing causes to the RVWLIS event are shift turnover distractions, a heavy workload of un-prioritized jobs and emergent work pressures. All personnel interviewed stated that despite the pressures, they would not have taken the "B" loop OOS had they realized the actual status of the "A" loop. Root Cause of the event is inadequate tracking of Technical Specification requirements by

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

Operations Personnel and lack of consideration of systems affected by Reactor Vessel Water Level Instrumentation (RVWLIS) by Operations personnel..

# D. SAFETY ANALYSIS:

The safety significance for this event was minimal. Reactor Vessel Water Level Indication was available on the Wide Range instrument. The Wide Range instrument loop is an indication only channel which has a range form -70 to +330 inches. The level in the reactor prior to and during the time of this event was such that all instrumentation was reading high except for the Wide Range Indicator. Reactor Water Level was being maintained between +48 and +70 inches. During this event, there were no known activities in progress that had the potential to drain the reactor vessel. In addition, Emergency Core Cooling Systems (ECCS) were available to be manually started as needed. The Shutdown Cooling (SDC) system was also operating. SDC does no provide make-up capability but was providing a cooling for the reactor water. Although automatic ECCS initiations was unavailable for eight hours, the safety significance of this event was minimal due to the conditions of the Unit at the time.

### E. CORRECTIVE ACTIONS:

Following the initial investigation, all OOS work was stopped until the Operations Managers briefed all shift personnel on this event. The briefing stressed the importance of ensuring that all Technical Specifications, Administrative requirements and FSAR requirements are met when taking equipment out-of-service. The briefing also addressed managements expectations on handling time pressure issues and that schedule is secondary to taking the time to self check and doing a good pre-job brief. The Operations Managers counseled all Field Supervisors and Unit Supervisors that the Field Supervisors must inform the Unit Supervisors of equipment to come out of service and that the Unit Supervisor must ensure all Tech Spec/FSAR requirements are met.

An experienced Field Supervisor was assigned as a coach for the new Field Supervisors on shift to help them prioritize and manage their workload. In addition, a pre-job brief checklist is now being used for all jobs that involve operation of equipment. This checklist addresses Tech Spec requirements.

An improved method of displaying the current status of each train of ESF equipment will be established. This display will be maintained by and readily available to the Control Room personnel to assist them when making decisions concerning affected systems.

#### F. PREVIOUS OCCURRENCES:

## LER/Docket Number Title

05000237/93-017

Unusual Event not Declared when Both Unit 2 and 2/3 Diesel Generators were Inoperable at the Same Time due to Personnel Error.

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# G. COMPONENT FAILURE DATA:

Not Applicable

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