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Dresden Generating Station
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ComEd

November 1, 1994

JSPLTR 94-0015

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

Licensee Event Report 94-027-01, Docket 50-237 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10CFR50.73(a)(2)(vii).

Sincerely,

J. Stephen Perry
Vice President
BWR Operations

JSP/TT: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)	DOCKET NUMBER (2)	PAGE (3)
Dresden Nuclear Power Station, Unit 2	05000237	1 OF 4

TITLE (4): Both RVWLIS Loops Inadvertently Removed From Service 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
09	22	94	94	-- 027 --	01	10	21	94	None	
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	N
POWER LEVEL (10)	000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.2201(b)		20.2203(a)(3)(i)		50.73(a)(2)(iii)		73.71(b)
	20.2203(a)(1)		20.2203(a)(3)(ii)		50.73(a)(2)(iv)		73.71(c)
	20.2203(a)(2)(i)		20.2203(a)(4)		50.73(a)(2)(v)		OTHER
	20.2203(a)(2)(ii)		50.36(c)(1)	X	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)		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	TELEPHONE NUMBER (Include Area Code)
T. Theesfeld, Operations Staff Ext. 3572	(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		11	01	94

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. This supplement is to address additional causal factors.

EVENT IDENTIFICATION:

Both RVWLIS Loops Inadvertently Removed From Service Due to Personnel Error

A. 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%

Reactor Coolant System Pressure: 0 psig

B. DESCRIPTION OF EVENT:

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 work delays 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 the scope of the OOS affected more 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 question the "B" Loop OOS nor recognize that the "A" Loop level indication was still unavailable. 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.

C. 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 Reactor Vessel Water Level Instrumentation (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 Operations Personnel and lack of consideration of systems affected by the RVWLIS work by Operations personnel. Management did not ensure shift personnel understood the scope of the outage for the RVWLIS modification installation. Management did not ensure the conservative thought process existed for maintaining one RVWLIS train operable as they had previously decided to do. Therefore, management expectations were not effectively conveyed, and poor communications existed within the Operations Department.

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 not provide make-up capability but was providing a cooling for the reactor water. Although automatic ECCS initiation 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.

G. COMPONENT FAILURE DATA:

Not Applicable