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Dresden Generating Station
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ComEd

April 12, 1996

JSPLTR #96-0058

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

Enclosed is Licensee Event Report 96-006, Docket 50-237 which is being submitted pursuant to 10CFR73(a)(2)(iv) which requires the reporting of any event or condition which results in manual or automatic actuation of any Engineered Safety Feature (ESF).

This correspondence contains the following commitments:

1. Training will be performed with Operations Teams on how to practice deliberate decision making and avoiding hasty responses. (2371809600601)

2. This event will be covered during an Operations Lessons Learned lecture, which will stress the importance of self checking prior to taking action. (2371809600602)

If you have any questions, please contact Pete Holland, Dresden Regulatory Assurance Supervisor at (815) 942-2920 extension, 2714.

Sincerely,

J. Stephen Perry
Vice President
BWR Operations

Enclosure

cc: H. Miller, Regional Administrator, Region III
NRC Resident Inspector's Office
Illinois Department of Nuclear Safety

20006

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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 Nuclear Power Station, Unit 2	05000237	1 OF 4

TITLE (4)
Inadvertent Manual Scram While in Refuel Mode During Planned Periodic Surveillance Testing Due to Human 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	27	96	96	-- 006 --	00	04	12	96	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)	X	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)		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)
Ralph M. Fenili, Operations Staff Ext. 2917	(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)

On March 27, 1996, with Unit 2 in the Refuel mode and all rods inserted, Instrument Maintenance was performing planned periodic testing per DIS 1600-02, Drywell High Pressure Scram and Containment Isolation Switch Calibration. The Instrument Mechanic made the Nuclear Station Operator (NSO) aware that they were ready to trip one of the Drywell pressure switches and to expect the half scram, half group isolation and various annunciator alarms. The NSO made the Unit Supervisor aware of the expected alarms and approximately 2 minutes later, the expected alarms and Reactor Protection System de-energization were received. The NSO's action should have been to depress the panel acknowledge pushbutton, but as a result of a reflexive action, the NSO depressed the Channel A and B RPS manual scram push buttons. The NSO's incorrect action was as a result of failing to slow down and take a conscious, reflective action based on the panel indications. Corrective actions include counselling the involved individual, licensed operator training on deliberate decision making, and event lessons learned for Operators.

EVENT IDENTIFICATION:

Inadvertent Manual Scram While in Refuel Mode During Planned Periodic Surveillance Testing Due to Human Error

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 2 Event Date: March 27, 1996 Event Time: 1446

Reactor Mode: N Mode Name: Refuel Power Level: 0%

Reactor Coolant System Pressure: 0 psig

B. DESCRIPTION OF EVENT:

This report is submitted in accordance with 10CFR73(a)(2)(iv) which requires the reporting of any event or condition which results in manual or automatic actuation of any Engineered Safety Feature (ESF).

On March 27, 1996, with Unit 2 in the Refuel mode and all rods inserted, Instrument Maintenance was in the process of performing periodic planned testing per DIS 1600-02, Drywell High Pressure Scram and Containment Isolation Switch Calibration. This surveillance tested and calibrated the Drywell high pressure switches by loading the switches locally, resulting in the Control Room receipt of a half scram, half group isolation and associated annunciator alarms when each switch was placed in a trip condition. Prior to the Instrument Mechanic's trip of each high pressure switch, the control room operator is made aware of the intended IMD action, allowing him to prepare for the resultant panel alarms and RPS channel de-energization.

This surveillance was being performed through shift change for the operators, between the day and afternoon shifts. A Licensed Nuclear Station Operator (NSO), who had been performing extra duties on the day shift, volunteered to take over the Control Room surveillance duties, allowing the Unit and Auxiliary NSO's to perform their shift turnover. This was the beginning of the second 8 hour shift for this individual.

The Instrument Mechanic made the NSO aware that they were ready to trip one of the Drywell pressure switches and to expect the half scram, half group isolation and alarms at approximately 1444. This was acknowledged and repeated back by the NSO. The NSO made the Unit Supervisor aware of the expected alarms and proceeded to the 902-5 panel, from which he would acknowledge the alarms.

After approximately 2 minutes, the alarms and RPS de-energization produced by the testing was received. The NSO then performed a reflexive action, depressing the Channel A and B RPS manual scram push buttons. This occurred at 1446 hours and resulted in an ESF actuation.

At 1707 on March 27, 1996, an ENS notification (Notification Number 30184) of the event was made pursuant to 10CFR72(b)(2)(ii).

The post-event interview with the NSO determined that his incorrect action was as a result of failing to slow down and take a conscious, reflective action based on the panel indications. Interviews with the NSO and the Instrument Mechanic found that both individuals were clear in the alarms expected and the actions to be taken, as a result of the pressure switch trip. The NSO's action should have been to depress the panel alarm acknowledge pushbutton. The actual response was to depress the Channel A and B RPS manual scram push buttons. Time sequence from receipt of alarms to depressing of the manual scram push buttons was less than 3 seconds, reinforcing the observation that insufficient thought to take deliberate action occurred.

C. CAUSE OF EVENT:

The cause of the event was cognitive personnel error (NRC Cause Code A) by a licensed NSO. The licensed operator failed to recognize the actual plant condition and responded incorrectly to a control room alarm due to inadequate task self-checking.

The error was contrary to the actions expected by the inprogress instrument surveillance testing of approved plant procedure DIS 1600-02. No unusual adverse environmental conditions contributed to the event.

D. SAFETY ANALYSIS:

For this event, the control room operator took an action which was inappropriate for the operating condition, yet is inherently safe by the design of the Reactor Protection System (RPS). His depressing of the manual scram push buttons de-energized RPS, resulting in the CRD system attempting to insert all control rod drives to position "00". All CRD's were fully inserted prior to the initiation of the scram, thus there was no control rod motion and no change in reactor status occurred. The reactor was, and remained shutdown at all times during the event sequence, therefore the safety significance is deemed minimal.

E. CORRECTIVE ACTIONS:

1. The surveillance was halted, leaving the unit in a stable state.

2. The involved operator was removed from licensed duties and his performance evaluated through an interview with the Operations Manager. This interview determined that he understands his responsibilities toward self checking prior to taking action. The individual acknowledges his error and agrees with the root cause. The Operator received voluntary remediation and was reinstated to normal licensed duties.

3. Appropriate notifications were made to Station Senior Management. A 4 hour ENS reportability notification was made.

4. Training will be performed with Operations Teams on how to practice deliberate decision making and avoiding hasty responses. (2371809600601)

5. This event will be covered during an Operations Lessons Learned lecture, which will stress the importance of self checking prior to taking action. (2371809600602)

F. PREVIOUS OCCURRENCES:

Docket Number/LER	Title
05000237/94-018	Unit 3 Reactor Scram on Low Level Due to Programmatic Deficiency and Human Error
05000237/95-003	Unit 2 Technical Specification Violation During Idle Reactor Recirculation Pump Start Due to Management Deficiency
05000237/95-013	Inadequate Sampling of Service Water Effluent Due to Use of a Superseded Procedure and Recent System Configuration Change
05000237/96-004	Main Steam Safety Valve 2-0203-4G As Found Lift Setpoint Outside Tech Spec Limit Due to Setpoint Drift. (This event was reported remiss to the 30 day reportability requirement due to Operations Human Error in proper reportability screening.)
05000249/96-001	Inadvertent Start of the Unit 3 Diesel Generator Due to Personnel Error

G. COMPONENT FAILURE DATA:

None.