NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), 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 3	05000249	1 of 3

TITLE (4)
Inadequate corrective actions contributed to invalid Recirculation Loop Temperature Signal which causes Unit 3 Shutdown Cooling Isolation

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
									N/A	
03	05	1999	1999	002	00	04	02	1999	FACILITY NAME N/A	DOCKET NUMBER

OPERATING MODE (9)	5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more) (11)							
POWER LEVEL (10)	000		20.2201(b)		20.2203(a)(2)(v)		50.73(a)(2)(i)		50.73(a)(2)(viii)
			20.2203(a)(2)(i)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
			20.405(a)(1)(ii)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
			20.2203(a)(2)(ii)		20.2203(a)(4)	X	50.73(a)(2)(iv)		OTHER
			20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Timothy P. Heisterman (Regulatory Assurance) ext.: 3324	(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 1354 hours on February 01, 1999, while Unit 3 was in Mode 5 a spurious 350° degrees F isolation of the Shutdown Cooling System (SDC) occurred. Operations personnel performed steps in accordance with Dresden Operating Abnormal (DOA) 1000-1 and entered the appropriate Technical Specification (TS) Action Statement. The isolation was due to a spurious 350 degrees Recirculation loop temperature isolation signal. The isolation was immediately reset and SDC was restarted at 1402. TS Action statement exited at that time, as well as, DOA. Following the isolation, TS 3.2.A-1 was reviewed and the 350 degrees isolation function was bypassed in accordance with the guidance in DOA 1000-1. A procedure change was initiated and revised Dresden Operating Procedure (DOP) 1000-03 to disable the trip function since this function is only required to be operable in modes 1, 2 and 3. As a part of the follow-up actions, Operations personnel reviewed reportability requirements in accordance with the ComEd Reportability Manual. The Reportability Manual states that this event is not reportable, therefore no ENS call was made. Subsequent review of deficiency documents revealed that the Reportability Manual was in error and the event should have been reported. An ENS call was made on March 05, 1999 at 1840 hours. A revision request to the reportability manual was issued to correct the manual.

Based on a review of the event, several previous occurrences were identified. However, no evidence could be obtained which indicated that actions were taken to prevent recurrence. The cause of the isolation is attributed to inadequate corrective actions due to management oversight.

This LER is being submitted pursuant to 10 CFR 50.73(a)(2)(iv), which requires the reporting of any event or condition that results in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection system (RPS). The system was not in operation for approximately eight minutes. There was no temperature increase during the time that the system was not in operation

PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2527 MWt rated core thermal power

Energy Industry Identification System (EIIS) Codes are identified in the text as [XX] and are obtained from IEEE Standard 805-1984, IEEE Recommended Practice for System Identification in Nuclear Power Plants and Related Facilities.

EVENT IDENTIFICATION:

Inadequate corrective action contribute to invalid Recirculation Loop Temperature Signal which causes Unit 3 Shutdown Cooling Isolation.

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 3 Event Dates: February 01, 1999 Event Times: 1354 CST
February 02, 1999 1406 CST

Reactor Mode: 5 Mode Name: Refuel Power Level: 0

B. DESCRIPTION OF EVENT:

At 1354 hours on February 1, 1999 an isolation of the Shutdown Cooling (SDC) [BO] system occurred from receipt of an invalid actuation of a 350-degrees F Recirculation Loop temperature switch. The SDC system isolation valves, which also act as Primary Containment Isolation Valves (PCIS) fully isolated as designed. In accordance with Plant Operating procedure, the Nuclear Station Operator took immmediate action which included manually tripping the running SDC pump. In adddition operations personnel entered the drywell and performed a visual inspection of the local thermocouple to assess possible damage. No obvious damage was detected, therefore operations concluded that this was an inadvertent agitation of the thermocouple due to the work activities in the drywell. At 1402 hours (eight minutes into the event), Operations successfully realigned and restarted the SDC system.

At 1406 hours on February 2, 1999, Unit 3 experienced a second isolation of SDC to the Reactor Vessel. The appropriate procedure (DOA 1000-01) and Tech Spec 3.10.K, were entered. The isolation was attributed to the invalid actuation of a 350 degrees F Recirculation Loop temperature switch. The Operating Team reviewed Control Room indications and recognized that the trip signal was a momentary spike and could be immediately reset. The isolation was reset and SDC flow restored at 1412 hours (six minutes into the event) allowing the Tech Spec Action statement and DOA to be exited. Following the isolation, Tech Spec 3.2.A-1 was reviewed where the Operating Team determined that the 350 degrees F isolation was not required to be operable in Mode 4. Therefore to prevent the potential for future inadvertent isolations, jumpers were installed to defeat the trip in accordance with guidance provided in DOA 1000-01. A procedure change was promptly performed and revision to DOP 1000-03 to provide additional guidance regarding installation of the jumpers.

C. CAUSE OF EVENT:

Based on a review of the event, several previous occurrences were identified. However, no evidence could be obtained which indicated that actions were taken to prevent recurrence. The cause of this event was determined to be a Management/Quality Assurance Deficiency (NRC Cause Code E), as demonstrated by the failure to provide adequate corrective action in place to prevent recurrence.

D. SAFETY ANALYSIS:

Regarding the events of February 1 and 2, 1999 SDC flow was restored in less than 8 minutes. During this period, no increase in reactor moderator temperature was noted. Furthermore, the Operating Teams promptly recognized (and demonstrated) that the isolation was spurious and could be immediately reset, based upon the Control Room Recirculation Loop temperature recorder indication. In the event of a loss cooling, the expected time to boil was in excess of eight hours. The backup systems available during the isolation were one Shutdown Cooling loop aligned to the fuel pool and two Fuel Pool Cooling loops aligned to the fuel pool. The significance of having the SDC system isolation under the described conditions did not adversely impact the safety of the plant nor did it comprise the health and safety of the public. Therefore, the safety significance of this event is minimal.

E. CORRECTIVE ACTIONS:

1. Revised procedure DOP 1000-03, Shutdown Cooling Mode of Operation, to require installation of jumper to bypass the 350-degrees F temperature input in mode 4 or mode 5. (Complete)
2. Control of future Recirculation Loop temperature switch jumper installation will be added to the standardized outage schedule / plan to coordinate the performance of the activity when in mode 4 or 5 and Containment is open. (Complete)

F. PREVIOUS OCCURRENCES:

None.

G. COMPONENT FAILURE DATA:

None.