



Commonwealth Edison

Dresden Nuclear Power Station

R.R. #1

Morris, Illinois 60450

Telephone 815/942-2920

July 11, 1989

EDE LTR #89-551

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

Licensee Event Report #89-008-0, Docket #050249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73(a)(2)(i)(B).

E.D. Eenigenburg
Station Manager

Dresden Nuclear Power Station

EDE/jt

Enclosure

cc: A. Bert Davis, Regional Administrator, Region III
File/NRC
File/Numerical

8907190057 890711
PDR ADCK 05000249
S PDR

(0617k)

IE22
11

LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Dresden Nuclear Power Station, Unit 3 Docket Number (2) 0 15 10 10 10 12 14 19 Page (3) 1 of 0 4

Title (4) Fire Damper Discovered Obstructed by Welding Equipment Due to Management Deficiency

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 Names	Docket Number(s)															
0	6	1	7	8	9	8	9	0	10	18	0	10	0	7	1	1	8	9	0	15	10	10	10	1	1

OPERATING MODE (9) N

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> Other (Specify in Abstract below and in Text)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name: Brian Barth, Technical Staff Engineer Ext. Telephone Number: 8 1 5 9 4 2 1 -12 19 12 10

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

Expected Submission Date (15) Month Day Year

Yes (If yes, complete EXPECTED SUBMISSION DATE) NO

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On June 17, 1989 at 1130 hours with Unit 3 operating at 87% rated core thermal power, a welding cable and air hose were found routed through an unducted ventilation opening containing a fire damper in a fire wall separating the Unit 3 east Low Pressure Coolant Injection (LPCI) room and the Unit 3 High Pressure Coolant Injection (HPCI) room. The cable and hose were placed to support welding activity involved with a Unit 3 HPCI turbine steam supply valve drain pot piping support modification. An Operations Shift Supervisor immediately removed the obstructions since no fire watch individual was present as required by Technical Specification 3.12.F.2. The root cause of the event was determined to be management deficiency in that Mechanical Maintenance supervision did not identify the ventilation opening as being part of the fire barrier. Corrective action will include installation of duct work to prevent passage of obstructions through the fire damper. Safety significance was minimal as a fire watch was present during the welding activity and the HPCI room is equipped with an automatic fire suppression system. A previous event involving obstruction of a fire door was investigated under non-reportable event 12-3-89-41.

LICENSING EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)				Page (3)		
		Year	Sequential Number	Revision Number				
Dresden Nuclear Power Station	0 5 0 0 0 2 4 9	8 9	- 0 0 8	- 0 0	0 3	OF	0 4	

TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

A contributing factor to this event was previous removal of the supply duct work to the HPCI room. No screens were provided over the opening upon removal of the duct work to prevent passage of obstructions through the opening. This concern had been previously identified by a Technical Staff System Engineer and Work Request 77429 had been initiated for reinstallation of the duct work.

This report is submitted in accordance with 10CFR 50.73 (a)(2)(i)(B), which requires the reporting of any condition prohibited by the Technical Specifications.

D. SAFETY ANALYSIS OF EVENT:

The Unit 3 HPCI room is 28 feet in height and is located beneath the Unit 2/3 Diesel Generator room. The Unit 3 east LPCI room is 41 feet in height and is open to the ground floor of the Unit 3 Reactor Building by a stairway leading into the room. The wall between the Unit 3 HPCI room and the Unit 3 east LPCI room is a 3-hour rated fire barrier. The Unit 3 HPCI room contains an automatic preaction deluge suppression system actuated by heat detectors. The east LPCI corner room contains linear thermal detection both at the ceiling and at a mid-level grating, which would provide a control room alarm. Both of these systems were operable at the time of the event. Additionally, a fire watch was present while the welding activity was in progress.

In the event of a severe fire in either room, the fire dampers in the ventilation opening would actuate, closing against the welding cable and the air hose. A small opening would exist at the bottom of the ventilation opening. Flame passage through the remaining opening would be minimal because of the proximity of the damper to the floor and due to minimal combustibles in either room. If a fire started in the Unit 3 east LPCI room, it would not affect the Unit 2/3 Diesel Generator because of the small opening in the fire barrier and the deluge system in the Unit 3 HPCI room. A fire in the Unit 3 HPCI room would not propagate to the Unit 3 east LPCI room because the automatic deluge suppression system would control the extent of the fire and the small opening in the fire damper caused by the welding cable and air hose blockage would reduce the possibility of carryover. Furthermore, spread of fire between the Unit 3 east LPCI room and the Unit 3 HPCI room would not prevent achieving stable hot shutdown conditions in accordance with established 10 CFR 50 Appendix R safe shutdown procedures. Therefore, the safety impact of the welding cable and air hose routed through the fire damper opening was minimal.

E. CORRECTIVE ACTIONS:

The immediate corrective action was the removal of the welding cable and air hose from the ventilation opening by the Unit 3 Shift Foreman upon discovery. The long term corrective actions for this event include reconnection of the damper duct work. Work Request 77429 was written to reinstall this duct work (249-200-89-05201). Additionally, the Technical Staff System Engineer will review all other fire barriers at the station and verify that the ventilation openings either have duct work attached or screening in place to prevent passage of material through the opening. If appropriate, work requests will be initiated for duct work or screening installation (249-200-89-05202). Additionally, the frames for ventilation openings which do not have connected duct work will be painted red (249-200-89-05203).

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

FACILITY NAME (1) Dresden Nuclear Power Station	DISTRICT NUMBER (2) 0 5 0 0 0 2 4 9	LER NUMBER (3)						Page (3)		
		Year	///	Sequential Number	///	Revision Number				
		8 9	-	0 0 8	-	0 0	0 4	OF	0 4	

TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

F. PREVIOUS EVENTS:

A previous event involving obstruction of a fire door with a hose occurred on May 12, 1989. This event involved passing a hose through a Unit 3 Shutdown Cooling (SDC) [B0] pump room fire door and a ventilation opening between the SDC pump room and main steam line tunnel [SB] without obtaining prior approval of the Operations Shift Supervisor. This event was investigated under non-reportable event 12-3-89-41, and was not reportable as an LER because Unit 3 was in Cold Shutdown conditions at the time and as such the fire door involved was not required to be operable.

G. COMPONENT FAILURE DATA:

Because this event did not involve component failure, this section is not applicable. As fire barriers are not reportable to the NPRDS data base, an industry-wide NPRDS data base search for similar events was not performed.