

LICENSEE EVENT REPORT

CONTROL BLOCK: _____ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | I | L | D | R | S | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 4 | 1 | 1 | 1 | 1 | _____ | _____
7 8 9 14 15 25 26 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

CONT
0 1 | REPORT SOURCE | L | 0 | 5 | 0 | 0 | 0 | 2 | 3 | 7 | 1 | 0 | 0 | 2 | 8 | 2 | 0 | 3 | 1 | 7 | 8 | 3 |
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES
During normal operation, following a Torus Hi/Lo level alarm, the sightglass isolation and vent valves were reported to be open with no indication of excess make-up. Initial calculations indicate that primary containment leakage would have been in excess of Tech. Spec. 3.7.A.2. Safety significance was considered minimal since no event occurred during the time the valves were left open. There was no effect on public health or safety. Last occurrence of a valving error: R.O. 81-77, Docket 50-237.

0 9 | SYSTEM CODE | S | A | CAUSE CODE | A | CAUSE SUBCODE | B | COMPONENT CODE | V | A | L | V | E | X | COMP. SUBCODE | A | VALVE SUBCODE | L |
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

17 | LER/RO REPORT NUMBER | 8 | 2 | SEQUENTIAL REPORT NO. | 0 | 4 | 3 | OCCURRENCE CODE | 0 | 1 | REPORT TYPE | X | REVISION NO. | 2 |
21 22 23 24 25 26 27 28 29 30 31 32

ACTION TAKEN | H | FUTURE ACTION | F | EFFECT ON PLANT | Z | SHUTDOWN METHOD | Z | HOURS | 0 | 0 | 0 | ATTACHMENT SUBMITTED | Y | NRC-4 FORM SUB. | N | PRIME COMP. SUPPLIER | L | COMPONENT MANUFACTURER | R | 3 | 4 | 0 |
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS
1 0 | The cause was operator error in that the valves were left open. The valves were
1 1 | immediately closed. This event has been reviewed during operator retraining classes
1 2 | emphasizing its significance. A modification has been completed to remove the vent
1 3 | valve. The sightglass isolation valves are locked closed and are being administra-
1 4 | tively controlled.

1 5 | FACILITY STATUS | E | % POWER | 0 | 8 | 0 | OTHER STATUS | N/A | METHOD OF DISCOVERY | A | DISCOVERY DESCRIPTION | Operator Observation
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 6 | ACTIVITY CONTENT | Z | RELEASED OF RELEASE | Z | AMOUNT OF ACTIVITY | N/A | LOCATION OF RELEASE | N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 7 | PERSONNEL EXPOSURES NUMBER | 0 | 0 | 0 | TYPE | Z | DESCRIPTION | N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 3 | PERSONNEL INJURIES NUMBER | 0 | 0 | 0 | DESCRIPTION | N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE | Z | DESCRIPTION | N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

2 0 | PUBLICITY ISSUED DESCRIPTION | N/A | PDR | PDR | NRC USE ONLY
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

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ATTACHMENT TO LICENSEE EVENT REPORT #82-43/01X-2
COMMONWEALTH EDISON COMPANY (CWE)
DRESDEN UNIT 2 (ILDRS-2)
DOCKET # 050-237

During normal operation, a Torus Hi/Lo level alarm annunciated in the control room. An operator was dispatched to take a local torus level reading. The operator reported that the sightglass isolation and vent valves were found open. This condition was reviewed by the shift supervisor and the shift control room engineer. Based on that review, it was determined that: 1) there was no indication of excess make-up, 2) no problems identified maintaining Drywell/Torus differential pressure, and 3) no flow was observed from the vent. In their judgement, based on a review of the above information and considering the size of the valve (0.25 inch), even with the vent valve fully open, primary containment leakage would be less than 1.6 weight percent per day at 48 psig (T.S. 3.7.A.2). After additional review and subsequent calculations, (based on the FSAR page 5.2-6 pressure of 62 psia and temperature of 281 degrees F), it was determined that primary containment allowable leakage of 13.7 SCFM would have been exceeded with the subject valves open. However, a more realistic maximum calculated leakage based on Figure 5.2.11 of the FSAR (LOCA profile) was performed. The average flow rates for the periods 0-30 and 30-120 minutes were determined by integrating the time dependent flow rate. The average flow rate for the time period 0-30 minutes was determined to be 11.68 SCFM. The average flow rate for the time period 30-120 minutes was determined to be 10.16 SCFM. A station approved special procedure (82-10-84) was performed on the installed piping at various pressures. The flow rates measured at 48 psig and 27 psig were 15.0 SCFM and 9.7 SCFM respectively. In the unlikely event that a LOCA had occurred during the time the valves were open, the safety significance was considered minimal since off-site dose calculations for a flow rate of 18.46 SCFM (48 psig continuous containment pressure) and assuming no dilution in the secondary containment was 12.872 Rem (Noble Gas) and 1.44 Rem (Iodine). The last occurrence involving a valving error was reported by R.O. 81-77 on Docket 50-237.

The cause of the event was personnel error in that the valves were believed to have been left open following the last local torus level reading. The local torus level readings are taken at random times several times a week. The torus sightglass isolation and vent valves were immediately closed. A modification (M12-2-82-45) to remove the sightglass vent valve and install a plug in its place has been completed. The event has been reviewed during operator retraining classes, emphasizing the significance of this event. The sightglass isolation valves have been locked closed and are being administratively controlled using the following procedures: system valve checklist, locked valve checklist, and the operating procedure. Additionally, valve tags will be hung on all valves on the instrument line, which will include the normal valve position on the tag. The same actions were required on Dresden 3.

Based on the shift personnel's immediate review of the condition, they decided that prompt notification was not required. However, subsequent discussions with the operations duty supervisor revealed that prompt notification was appropriate and the proper notifications were made. Discussion of this judgement error was included in the retraining classes. As a result, shift personnel have been directed to contact the operations duty supervisor when a deviation report is initiated that could be classified as a reportable occurrence.