

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <b>Dresden Nuclear Power Station, Unit 3</b>	DOCKET NUMBER (2) <b>0 5 0 0 0 2 4 9</b>	PAGE (3) <b>1 OF 0 2</b>
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TITLE (4)  
**Automatic Initiation of Standby Gas Treatment and Isolation of Reactor Building Ventilation System 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 NAMES			DOCKET NUMBER(S)		
									N/A			0 5 0 0 0		
0 6	1 2	8 6	6 8	0 0	7	0 0	0 7	1 1	N/A			0 5 0 0 0		

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

OPERATING MODE (8) <b>N</b>	<input type="checkbox"/> 20.402(b)	<input checked="" type="checkbox"/> 20.405(c)	<input type="checkbox"/> 80.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
	<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 80.36(e)(1)	<input type="checkbox"/> 80.73(a)(2)(v)	<input type="checkbox"/> 73.71(n)
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 80.36(e)(2)	<input type="checkbox"/> 80.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input type="checkbox"/> 80.73(a)(2)(i)	<input type="checkbox"/> 80.73(a)(2)(viii)(A)	
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 80.73(a)(2)(ii)	<input type="checkbox"/> 80.73(a)(2)(viii)(B)	
	<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 80.73(a)(2)(iii)	<input type="checkbox"/> 80.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME <b>S. Merritt, Technical Staff Engineer</b>	TELEPHONE NUMBER <b>X-421</b>	AREA CODE	TELEPHONE NUMBER		
		<b>8 1 5</b>	<b>9 4 2 - 2 9 2 0</b>		

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)

YES (if yes, complete EXPECTED SUBMISSION DATE):  NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

On 6/12/86 at 1340 hours, with Unit 3 in shutdown for a refueling outage and all fuel removed from the core, a Group II isolation occurred. The standby gas treatment system (SBGT) automatically started and the Reactor Building ventilation system isolated.

In the process of taking a cable tray out of service the Reactor Operator inadvertently caused a Group II isolation while following an incorrectly prepared out of service request written by an Operating Foreman. Work was to be performed on cable tray CT-13T by the Electrical Maintenance Department. The cables in the cable tray had to be de-energized. The Unit 3 Reactor Operator removed fuse 595-718 of the 903-4 panel to de-energize the cables. The fuse energizes cables in tray CT-13T as well as two relays, 595-134 and 135, which initiate SBGT and isolate the Reactor Building ventilation system. The Operating Foreman preparing the out of service request overlooked the relays in the circuitry. Upon removal of the fuse, the systems automatically started and isolated as designed. The systems were returned to normal at 1428 hours.

To prevent recurrence, the error was discussed with the Operators involved concerning the necessity for using caution when preparing outages of this type.

The safety significance of this event was minimal since the SBGT and Reactor Building ventilation system initiated as required. A similar occurrence is reported on Licensee Event Report #85-037-0 on Docket #050237.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 6	- 0 0 7	- 0 0	0 2	OF 0 2

TEXT (If more space is required, use additional NRC Form 366A's) (17)

On 6/12/86 at approximately 1340 hours, with Unit 3 in shutdown for a refueling outage and all fuel removed from the core, the Unit 3 Reactor Operator inadvertently caused a Group II primary containment isolation while following an incorrectly prepared out of service request written by an Operating Foreman.

On 6/9/86 a walkdown of the cable trays located in the cable tunnel (elevation 502') was performed. Oil was discovered leaking from the electro-hydraulic control (EHC) unit on elevation 517' through cracks in the floor into some of the cable trays below. Work requests (WR) 54948 - 54950, 55108 - 55118, 55120 were initiated to clean the cable trays and repair cable jackets that may have been damaged by the oil.

On 6/12/86, cable tray CT-13T was to be taken out of service by the Operations Department for the Electrical Maintenance (EM) Department. In order to perform work in CT-13T, the cables within the tray had to be de-energized. The cables to be de-energized were 32400, 32402, 32428, 32433. The cables operate the drywell floor drain sump pump isolation valves AO-2001-105 and AO-2001-5. The valves are normally in the closed position while the unit is in the refuel mode.

Fuse 595-718, located in the rear of the 903-4 panel, feeds the logic circuitry for the drywell floor drain isolation valve indicators and solenoids as well as automatic initiation relays 595-134 and 135 for the standby gas treatment system (SBGT, EIIS Code BH) and isolation initiation for the Reactor Building ventilation system (EIIS Code VL). When preparing the out of service request, the Operating Foreman failed to realize that the SBGT and Reactor Building ventilation systems would be affected. When the Operator hung the outage and pulled the fuse, relays 595-134 and 595-135 de-energized, thus activating SBGT and isolating the Reactor Building ventilation system. The fuse was replaced. The systems were returned to normal at 1428 hours.

A subsequent review of the outage and electrical print was conducted. The Unit 3 Shift Foreman discussed the outage with the EM Department to find a different method of de-energizing the cables that would not affect another system. The outage was rewritten and individual cable leads were lifted rather than pulling a fuse.

The error was discussed with the Operators involved concerning the necessity for using caution when preparing outages of this type.

The safety significance of the event was minimal. The SBGT system automatically started as designed.

A similar event of this type was reported on Licensee Event Report #85-037-0 on Docket #050237.



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July 11, 1986

DJS Ltr #86-491

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

Licensee Event Report #86-007-0, Docket #050249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73 (a)(2)(iv).

D.J. Scott  
Station Manager

DJS/kjl

Enclosure

cc: J.G. Keppler, Regional Administrator, Region III  
File/NRC  
File/Numerical

IE22  
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