

LICENSEE EVENT REPORT

U. S. NUCLEAR REGULATORY COMMISSION
UPDATED REPORT
PREVIOUS REPORT DATE: 11/24/82

CONTROL BLOCK: | | | | | 1

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	I	L	D	R	S	2	0	0	-	0	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4		5			
7	8	9	LICENSEE CODE					14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	37	CAT		58

CONT

0	1	L	5	0	5	0	0	0	2	3	7	7	1	0	0	2	8	2	3	0	3	1	7	8	3	9							
7	8	REPORT SOURCE					50	51	DOCKET NUMBER										58	59	EVENT DATE					74	75	REPORT DATE					80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

0 2 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.

0 3 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	S	A	11	A	12	B	13	V	A	L	V	E	X	14	A	15	L	16	8	2	0	4	3	0	1	X	2												
7	8	SYSTEM CODE		9	10	CAUSE CODE		11	12	CAUSE SUBCODE		13	COMPONENT CODE			14	COMP. SUBCODE		19	VALVE SUBCODE		20	LER/RO REPORT NUMBER		21	EVENT YEAR		22	SEQUENTIAL REPORT NO.		24	OCCURRENCE CODE		27	REPORT TYPE		30	REVISION NO.		32
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPR-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER																								
H		F		Z		Z		0		Y		N		L		R		3		4		0																		
33		34		35		36		37		40		41		42		43		44		45		46		47		48		49		50		51		52		53		54		

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

1 0 The cause was operator error in that the valves were left open. The valves were immediately closed. This event has been reviewed during operator retraining classes emphasizing its significance. A modification has been completed to remove the vent valve. The sightglass isolation valves are locked closed and are being administratively controlled.

1	5	E	0	8	0	29	N/A	30	A	31	Operator Observation	32							
7	8	FACILITY STATUS		9	10	% POWER		11	12	OTHER STATUS		13	METHOD OF DISCOVERY		14	DISCOVERY DESCRIPTION		15	
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY		LOCATION OF RELEASE													
Z		Z		N/A		N/A													
33		34		35		36		37		38		39		40		41		42	
PERSONNEL EXPOSURES		TYPE		DESCRIPTION															
0		0		Z		N/A													
11		12		13		14		15		16		17		18		19		20	
PERSONNEL INJURIES		NUMBER		DESCRIPTION															
0		0		N/A															
11		12		13		14		15		16		17		18		19		20	
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION															
Z		N/A																	
11		12		13		14		15		16		17		18		19		20	
PUBLICITY		ISSUED		DESCRIPTION															
N		N/A																	
11		12		13		14		15		16		17		18		19		20	

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PDR ADOCK 05000237
S PDR

NRC USE ONLY

NAME OF PREPARER

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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.