NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Dresden Nuclear Power Station	0 5 0 0 0 2 4 9	1 OF 0 2

TITLE (4)
HPCI Room Cooler Inoperability

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 2	2 2	8 5	8 5	0 0 6	0 0	0 3	1 8	8 5	N/A	0 5 0 0 0

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10) 1 0 0		20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Lawrence Coyle (X-483)	AREA CODE 8 1 5 9 4 2 - 2 9 2 0

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	
A	B J			N							

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 fifteen single-space typewritten lines) (16)

During normal operation the Operating Department discovered that the service water leading to the Unit 3 HPCI room cooler was valved out, causing it and the HPCI system to be inoperable. Safety significance was minimal since the isolation condenser and automatic depressurization systems were operable and capable of relieving high reactor pressure. The valves were immediately opened and system operability was restored.

The cause of the event was personnel error. An investigation revealed that station personnel valved out the service water supply to the Unit 3 HPCI room cooler sometime between 1/14/85 and 1/23/85, without proper authorization. Results of this investigation produced a list of recommendations for corrective actions. One of these corrective actions is that all service water supply valves to HPCI, LPCI, and containment cooling service water vault coolers will be locked open to prevent a recurrence. This is the first occurrence of an event of this type.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Dresden Nuclear Power Station, Unit 3	0 5 0 0 0 2 4 9	8 5	— 0 0 6	— 0 0	0 2 OF 0 2

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

During normal operation, the Operating Department was requested to investigate the status of the HPCI room coolers per Unit 3 Operating Daily Orders, because of complaints of the high HPCI room temperature. Operating personnel discovered that the service water leading to the Unit 3 HPCI room cooler was valved out causing it and the HPCI system to be inoperable. Safety significance was minimal since the isolation condenser and the ADS system were operable and capable of relieving high reactor pressure. The valves were immediately opened and system operability was restored. All other room coolers for LPCI/ core spray and HPCI were verified to have service water valved in.

Immediately after the discovery, an investigation was undertaken by plant personnel to determine the past evolution of the service water supply valve to the HPCI room cooler. The Unit 3 NSO and Shift Engineer's log books were reviewed along with previous out of service requests and work requests. No record of manipulation of the service water supply valve from September 1, 1984 to the discovery of the event could be found. However, an aid to this investigation occurs from the circumstances surrounding the operation of the cooler. When service water is supplied to the HPCI room coolers, heavy condensation appears on the service water piping in and around the coolers. This results in dripping water overhead near the HPCI room entrance which is noticeable to personnel entering the room. Past work requests and surveillances were reviewed to determine plant personnel who had worked in the area of the HPCI room coolers and had noticed the water dripping. After interviewing different departments, the latest date determined for the operability of the Unit 3 HPCI room cooler was 1/14/85, as witnessed by the Electrical Maintenance Department working in the area. The next recorded date of individuals working in the area occurred on 1/23/85, when the HPCI Operability Surveillance (DOS 2300-1) was being performed. The Operating personnel involved in the area did not recall water dripping from overhead of the HPCI room entrance. We believe that during the time period from 1/14/85 to 1/23/85, station personnel, either misinterpreting the dripping water to be a leaking cooler or to improve working conditions in the area, valved out the service water supply to the Unit 3 HPCI room cooler without proper authorization. This is the first occurrence of an event of this type.

Because of the HPCI room cooler event, a parallel investigation was initiated to determine whether other ECCS systems could experience a similar event. The results of these investigations have produced the following recommendations:

1) All associated service water supply valves to HPCI, LPCI, and containment cooling service water vault coolers will be locked open.
2) These valves will be added to the locked valve checklists and also added to their respective system checklists.
3) Verification of the operability of room coolers will be added to the Operating Surveillances of the respective systems.
4) Since the above corrective actions specifically impact Operating Department procedures, the corrective actions will be discussed with Operating personnel during the six week retraining program.

Dresden Station believes the corrective actions listed will prevent a recurrence of this event.

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March 19, 1985

DJS Ltr #85-308

U.S. Nuclear Regulatory Commission
Document Control Desk
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Licensee Event Report #85-006-0, Docket #050249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73 (a)(2)(v).

D.J. Scott
Station Superintendent
Dresden Nuclear Power Station

DJS/kjl

Enclosure

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

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