

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Dresden Nuclear Power Station, Unit 3										DOCKET NUMBER (2) 0 5 0 0 0 1 2 4 9				PAGE (3) 1 OF 0 2					
TITLE (4) Reactor Building Ventilation Isolation and Automatic Initiation of Standby Gas Treatment Due to Fuel Handler 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)						
0 9	2 4	8 5	8 5	0 2 6	0 0 1 2	1 9	8 5		Dresden Unit 2				0 5 0 0 0 2 3 7						
									N/A				0 5 0 0 0						
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																	
N		20.402(b)				20.406(e)				X 50.73(a)(2)(iv)				73.71(b)					
POWER LEVEL (10)		0 1 0 0				50.36(c)(1)				50.73(a)(2)(v)				73.71(e)					
		20.406(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 365A)					
		20.406(a)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(viii)(A)									
		20.406(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)									
		20.406(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)									
LICENSEE CONTACT FOR THIS LER (12)																			
NAME										TELEPHONE NUMBER									
Michael Moy										AREA CODE 8 1 5 9 4 2 - 2 9 2 0									
(X-428)																			
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																			
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC
A				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)

On September 24, 1985 at 1312 hours and while Unit 3 was shutdown, the Unit 3 reactor building ventilation system tripped and isolated. The "A" train of the standby gas treatment system immediately started as required. The Unit 2 reactor building ventilation system was manually tripped and isolated. The initial ventilation trip was caused by a refueling floor channel "B" high radiation signal. At 1342 hours the Unit 2 and Unit 3 reactor building ventilation systems were started and the standby gas treatment system was secured.

Following a high radiation alarm in the control room, the Station Control Room Engineer was notified by the Fuel Handling Department that the refueling floor area radiation monitor had initiated as they were moving a discharged local power range monitor within the fuel pool.

The cause of the event can be attributed to personnel error. The event was discussed with the Fuel Handling Department Lead Foreman and he was made more aware of the necessity for using extreme caution when moving local power range monitors.

The safety significance of the event was minimal since radiation dose to the Fuel Handlers involved was minimal, the Unit 3 reactor building ventilation tripped as required, and the "A" train of the standby gas treatment system started as designed. Further, the redundant "B" train of the SGBT system was available for operation.

An event of this type last occurred on September 5, 1985 and was reported by Licensee Event Report #85-017 on Docket #050249. A copy of the original deviation report describing this event was misplaced and never forwarded to the Technical Staff for processing. On 12/11/85, while reviewing the Emergency Notification System log, the oversight was discovered. As a result, this report was not submitted by the 10/23/85 due date.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

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 3 9 8 5	—	0 2 6	—	0 0	0 2	OF 0 2

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

On September 24, 1985 at 1312 hours and while the unit was shut down, the Unit 3 reactor building ventilation system tripped and isolated. The "A" train of the standby gas treatment system (BH) immediately started as required. The Unit 2 reactor building ventilation system was manually tripped and isolated per Operating Order 1-85. The initial ventilation trip was caused by a refueling floor channel "B" high radiation signal. At 1342 hours the Unit 2 and Unit 3 reactor building ventilation systems were started and the standby gas treatment system was secured.

Upon discussion with the Station Control Room Engineer (SCRE) on shift at the time of the event, it was discovered that a refueling floor high radiation alarm was received in the control room. Following the alarm the SCRE received a telephone call from the Fuel Handling Department notifying him that the refueling floor area radiation monitor had initiated as they were moving a discharged local power range monitor (LPRM) within the fuel pool. The discharged LPRM was being moved to a cutting station also within the fuel pool for processing. The LPRM was brought too near the surface of the water and initiated the radiation monitor.

The cause of the event can be attributed to personnel error. The event was discussed with the Fuel Handling Department Lead Foreman and he was made more aware of the necessity for using extreme caution when moving local power range monitors. The safety significance of the event was minimal since the radiation dose to the Fuel Handlers involved was minimal, the Unit 3 reactor building ventilation tripped as required and the "A" train of the standby gas treatment system started as designed. Further, the redundant "B" train of the SGBT system was available for operation.

An event of this type last occurred on September 5, 1985 and was reported by Licensee Event Report #85-017 on Docket #050249.

On December 11, 1985, while reviewing the Emergency Notification System (ENS) telephone log, the Unit 2 Technical Staff Group Leader discovered that a one hour telephone notification of this event had been made to the Nuclear Regulatory Commission. However, the required 30 day written report had not as yet been submitted. A review of the Shift Engineer's log indicated that a written deviation report describing this event had been written. However, the deviation report had not been forwarded to the Technical Staff. As a result, this written report was not submitted to the NRC by the 10/23/85 due date. It is not known how the original deviation report was lost. As this is an isolated incident, no further action will be taken. The ENS telephone log will continue to be periodically reviewed by the Technical Staff Group Leaders.



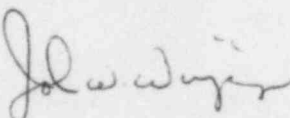
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December 19, 1985

DJS Ltr #85-1172

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

Licensee Event Report #85-026-0, Docket #050249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73 (a)(2)(iv).

  
for D.J. Scott  
Station Manager  
Dresden Nuclear Power Station

DJS/kjl

Enclosure

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

IE22  
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