

Commonwer Edison Dresden Nuclear Power Station R.R. #1 Morris, Illinois 60450 Telephone 815/942-2920

October 13, 1978

BBS Ltr. #78-1368

James G. Keppler, Regional Director Directorate of Regulatory Operations - Region III U.S. Nuclear Regulatory Commission 799 Roosevelt Road Glen Ellyn, IL 60137

Reportable Occurrence Report #78-055/01T-0, Docket #050-237 is hereby submitted to your office in accordance with Dresden Nuclear Power Station Technical Specification 6.6.B.1.(e), failure or malfunction of one or more components which prevents or could prevent, by itself, the fulfillment of the functional requirements of system(s) used to cope with accidents analyzed in the SAR.

Stephenson

Station Superintendent Dresden Nuclear Power Station

BBS/deb

Enclosure

cc: Director of Inspection & Enforcement Director of Management Information & Program Control File/NRC

REGULATORY DOCKET FILE COPY



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THE FURNIN SUD. (7-77) LICENSEE EVENT REPORT CONTROL BLOCK:] $\mathbf{J}(\mathbf{i})$ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) $0_{25}3_{26}$ | L | D | R | S | 2 | (2) |0 0 0 0 0 0 0 - 0 (5) LICENSE NUMBER LICENSEE CODE CON'T. 7 8 8 REPORT 60500100012370093011 0 1 3 7 8 (9) 0 1 L SOURCE 68 DOCKET NUMBER EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) While performing DOS 2300-3 (HPCI Turbine Quarterly Surv.) the HPCI turbine tripped 0 2 on low pump suction pressure of 11.5 psig which exceeds the Dresden setpoint of 9.4 0 3 in. Hg vacuum increasing. Safety significance was reduced since redundant Isolation 0 4 Condenser and Auto Depressurization Systems were operable. No previous similar 0 5 events at Dresden. 0 6 0 7 0 8 g 80 SYSTEM CODE CAUSE CAUSE COMP. VALVE CODE SUBCODE COMPONENT CODE SUBCODE SUBCODE E (12 E (13) E (15 Z (16) 0 9 Ι N S ·R U (14 19 SEQUENTIAL OCCURRENCE REVISION REPORT LER/RO EVENT YEAR REPORT NO. CODE TYPE NO. (17) REPORT 8 0 1 0 5 5 5 T 0 NUMBER 28 31 32 ACTION FUTURE TAKEN ACTION EFFECT ON PLANT COMPONENT SHUTDOWN ATTACHMENT SUBMITTED NPRD-4 PRIME COMP. HOURS (22) METHOD FORM SUB. SUPPLIER MANUFACTURER M 2 3 $Z^{(21)}$ E](18)[<u>7</u> (19) <u>Z</u> (20) 0 0 0 0 0 <u>y</u> (23) Y _(24) N (25) (26) 36 CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The cause was attributable to instrument drift of pressure switch PS 2-2360. 10 The switch was recalibrated to trip at -9.4" Hg increasing. The switch will be checked $\overline{}$ in two months to ensure its continued acceptability. 1 2 1 3 4 9 80 FACILITY METHOD OF DISCOVERY OTHER STATUS (30) % POWER DISCOVERY DESCRIPTION (32) . 2]29 E (28) 0 9 NA B (31) 5 Surveillance Testing 10 12 80 CONTENT ACTIVITY AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36) RELEASED_OF RELEASE NA 6 NA 10 80 11 PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER 0 0 n (38 PERSONNEL INJURIES 13 80 DESCRIPTION (41) NUMBER 8 NA ā 11 8 12 80 UOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION TYPE **'9**' <u>Z</u> (42) NA 10 80 PUBLICITY NRC USE ONLY DESCRIPTION (45) ISSUED N (44 0 NA 8 9 10 68 69 80 5 810200097 0 X-289 Lindberg <u>Carl</u> ME OF PREPARES PHONE

ATTACHMENT TO LICENSEE EVENT REPORT 78-055/01T-0 COMMONWEALTH EDISON COMPANY (CWE) DRESDEN UNIT-2 (ILDRS-2) DOCKET #050-237

While conducting the HPCI Turbine Quarterly Surveillance DOS 2300-3, the HPCI Turbine tripped on low pump suction pressure sensed by pressure switch PS-2-2360. The switch tripped at 11.5 psig which is considerably above the Dresden setpoint of 9.4" Hg vacuum increasing. The safety significance of the event was reduced since the redundant Isolation Condenser and Automatic Depressurization Systems were operable.

In the surveillance procedure, normally closed MO valves 2-2301-14 (Flow to Torus), 2-2301-10 (Flow to 2/3B Contaminated Condensate Storage Tank), and 2-2301-49 (HPCI bypass line) are all opened and the HPCI turbine is started against little backpressure. Using a temporary procedure change, valve 2301-10 was closed to restrict the pumps discharge and HPCI started normally. Valve 2301-10 was subsequently throttled and proper flows and pressures were obtained to satisfactorily demonstrate operability in accordance with the surveillance requirements.

However, after subsequent management review on the next normal working day, it was concluded that HPCI might not have been operational under all accident conditions and should have been reported inoperable in accordance with Technical Specifications 6.6.B.l.e.

The cause of the trip was instrument drift of PS2-2360. The switch was recalibrated to trip at 9.4 inches Hg vacuum increasing. These switches have been calibrated each refueling outage in the past, and a review of records indicates no unusual tendency for excessive drifting of the switch setpoints. The switch will be checked in two months to ensure its continued acceptability.