



Commo Health Edison

Dresden Nuclear Power Station

R.R. #1

Morris, Illinois 60450

Telephone 815/942-2920

July 7, 1992

CWS LTR #92-367

U.S. Nuclear Regulatory Commission
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Licensee Event Report #92-15, Docket #050249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR50.73(a)(2)(iv).

L. J. Newer for 7/8/92

Charles W. Schroeder
Station Manager
Dresden Nuclear Power Station

CWS/jmt

Enclosure

cc: A. Bert Davis, Regional Administrator, Region III
NRC Resident Inspector's Office
File/NRC
File/Numerical

(ZDVR/658)

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Dresden Nuclear Power Station, Unit 3	Docket Number (2) 0 15 10 10 10 12 14 19	Page (3) 1 of 0 4
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Title (4) LPCI Minimum Flow Valve M03-1501-13A Auto Closure During Valve Operability Test Due to Unknown Cause

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 6	1 4	9 2	9 2	0 1 5	0 0	0 7	0 7	9 2	N/A	
									N/A	

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)																				
POWER LEVEL (10) 0 5 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input checked="" type="checkbox"/> 50.73(a)(2)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	<input type="checkbox"/> 50.73(a)(2)(x)	<input type="checkbox"/> 73.71(b)	<input type="checkbox"/> 73.71(c)	<input type="checkbox"/> Other (Specify in Abstract below and in Text)

LICENSEE CONTACT FOR THIS LER (12)

Name Sang J. Rhee Technical Staff System Engineer Ext. 2371	TELEPHONE NUMBER AREA CODE 8 1 5 9 4 2 -12 19 12 10
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

<input checked="" type="checkbox"/> Yes (If yes, complete EXPECTED SUBMISSION DATE) <input type="checkbox"/> NO	Expected Submission Date (15) 0 2 2 8 9 3
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ABSTRACT (Limit to 1400 spaces, i.e, approximately fifteen single-space typewritten lines) (16)

On June 14, 1992 at 1915 hours with Unit 3 at 50% rated core thermal power, while performing Dresden Operating Surveillance (DOS) 1500-1, LPCI System Valve Operability Test, the LPCI minimum flow valve, M03-1501-13A, spuriously auto closed when the outboard LPCI Injection valve, M03-1501-21A, was being returned to the normally open position. The M03-1501-21A valve had been closed first to cycle the M03-1501-22A valve (inboard LPCI Injection) in accordance with DOS 1500-1. The LPCI minimum flow valve was repositioned back to the open position immediately. The LPCI valve operability test was continued, and the LPCI minimum flow valve closed a second time when the A LPCI Loop Outboard Torus Cooling/Test Valve, M03-1501-38A was cycled. Review of this event has not identified an exact root cause of the LPCI minimum flow valve M03-1501-13A auto closure when the M03-1501-21A was returning to the normally open position. However, it is postulated that when the M03-1501-22A valve is cycled, an increase in pressure in the piping volume bordered by valves M03-1501-21A, M03-1501-38A, and A03-1501-25A may have resulted due to a small amount of leakage from the reactor recirculation system into this volume through LPCI testable injection check valve, A03-1501-25A. Closure of M03-1501-13A when M03-1501-38A was cycled is believed to be caused by the Torus Cooling Loop being repressurized during the valve operability surveillance, and flow being sensed by the minimum flow valve closure logic. Investigation is continuing concerning closure of M03-1501-13A when positioning M03-1501-21A. This event had minimal safety significance because the LPCI minimum flow valve would have auto opened under LPCI initiation logic if necessary under accident conditions. A similar event was reported by LER 92-12/050249.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

Form Rev 2.0

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						Page (3)		
		Year	///	Sequential Number	///	Revision Number				
Dresden Nuclear Power Station	0 5 0 0 0 2 4 9	9 2	-	0 1 5	-	0 0	0 3	OF	0 4	

TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

Upon further investigation/testing on July 2, 1992 under WR 09840, it was discovered that the volume between the M03-1501-38A(B) and the Inboard Torus Cooling/Test Valve M03-1501-20A(B) was depressurized during the previous LPCI System Valve Operability test. Since the LPCI System Valve Operability test is performed on a monthly basis, the completion of the previous surveillance leaves the volume of piping between the M03-1501-38A(B) and M03-1501-20A(B) depressurized. Subsequently, when the M03-1501-38A(B) valve is cycled, an instantaneous flow is apparently sensed by the flow element as the volume repressurizes, resulting in the closure of the LPCI minimum flow valve, M03-1501-13A(B).

D. SAFETY ANALYSIS OF EVENT:

The function of valves M03-1501-13A and -13B is to provide a minimum flow path for the LPCI pumps in order to prevent pump damage. The valves are repositioned based on system flow. At the time the valves went closed, the pumps were not operating and redundant low pressure emergency cooling systems were unaffected. The valves were repositioned back to open position immediately. Momentary closing of the LPCI minimum flow valves presented minimal potential for damaging the pumps as damage would occur only after prolonged operation with no minimum flow protection. Furthermore, the minimum flow valves would have automatically opened if necessary via LPCI initiation logic under accident conditions. Safety significance of this event is therefore considered minimal.

E. CORRECTIVE ACTIONS:

Investigation/testing was performed by the Operations Department, Instrument Maintenance Department, and Technical Staff to duplicate the event. Immediate corrective actions were: 1) Check the calibration of LPCI discharge header flow transmitter (FT 3-1501-58A) (found satisfactory), 2) Flush and vent the common high and low flow transmitter sensing lines to ensure free of air bubbles. Temporary Procedure Changes (TPC) 92-192 and 92-193 against DOS 1500-1 and DOS 1600-1, (Quarterly Valve Timing), were implemented on April 24, 1992. The changes consisted of a caution to warn the operators of the potential LPCI minimum flow valve auto closure when cycling the M02(3)-1501-38A(B). Further investigation will be performed to determine the root cause of the M03-1501-13A auto closure when M03-1501-21A was being returned to the normally open position, and a supplemental report will be submitted by the System Engineer (249-200-92-08401).

F. PREVIOUS OCCURENCES:

LER/Docket Numbers Title

12-3-92-12/050249 LPCI Minimum Flow Valve M03-1501-13A Auto Closure During Valve Operability Test Due to Unknown Cause.

While performing DOS 1500-01, LPCI System Valve Operability Test, the LPCI minimum flow valve, M03-1501-13A, auto closed when the LPCI Torus Cooling/Test valve, M03-1501-38A, was cycled. Investigation suggested (see section C above) that the volume between the M03-1501-38A and M03-1501-20A was depressurized during the previous monthly LPCI System Valve Operability test. Subsequently, when M03-1501-38A was cycled, an instantaneous flow was sensed by the flow element as the volume repressurized resulting in the closure of the M03-1501-13A.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						Page (3)		
		Year	Sequential Number	Revision Number						
Dresden Nuclear Power Station	0 5 0 0 0 2 4 9	9 2	- 0 1 5	-	0 0	0 4	0 F	0 4		

TEXT Energy Industry Identification System (EIIIS) codes are identified in the text as [XX]

12-2-92-08/050237 Unanticipated Valve LPCI Minimum Flow Valve M02-1501-13B Closure Due to Spurious Master Trip Unit Spike During Calibration.

While performing Dresden Instrument Surveillance (DIS) 2300-3, High Pressure Coolant Injection Low Reactor Pressure Isolation Master Trip Unit (MTU) Calibration, the LPCI minimum flow valve, M02-1501-13B inadvertently closed due to a spurious MTU spike.

12-2-91-26/050237 Unanticipated Valve Closures During 125 VDC Ground Checking Due to Procedure Deficiency.

While performing DOP 6900-06, 125 VDC Ground Detection, the LPCI minimum flow valve M02-1501-13A inadvertently closed due to loss of power in the circuit. Although the circuit design causes this closure on de-energization of power, DOP 6900-06 did not state this would occur.

G. COMPONENT FAILURE DATA:

This event at this time is not classified as a component failure; therefore, this section is not applicable.