Commonwealth Edison Company Dresden Generating Sta 6500 North Dresden Ro Morris, IL 60450 Tel 815-942-2920



May 12, 1995

TPJLTR 95-0054

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

Licensee Event Report 95-009, Docket 50-249 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10CFR50.73(a)(2)(v)(D).

Sincerely,

Thomas P. Joyce

Site Vice President

TPJ/PKG:cfq

Enclosure

cc: J. Martin, Regional Administrator, Region III

NRC Resident Inspector's Office

File/NRC

File/Numerical

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NRC FO (5-92)	RM 366	S. NUCLEAR REGULATORY COMMISSION								PROVED BY ONB MO. 3150-0104 EXPIRES 5/31/95								
LICENSEE EVENT REPORT (LER) LICENSEE EVENT REPORT (LER) ESTIMATED BURDEN PER RESPONDENT IN THE INFORMATION COLLECTION FORWARD COMMENTS REGARDING THE INFORMATION AND RECORD (MNBB 7714), U.S. NUCLEAR WASHINGTON, DC 20555-0001, REDUCTION PROJECT (3150 MANAGEMENT AND BUDGET, WASH									LLECTION GARDING RECORDS CLEAR REG	REQUES BURDEN MANAG ULATOR' ND TO 1	T: 50.0 HRS. ESTIMATE TO EMENT BRANCH Y COMMISSION,							
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Paul Garrett, Plant Engineering Ext. 2713 (815) 942-2920																		
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

SUPPLEMENTAL REPORT EXPECTED (14)

(If yes, complete EXPECTED SUBMISSION DATE).

On April 16, 1995, at 1358 hours, with Unit 3 at 97% rated core thermal power, during Nuclear Station Operator (NSO) panel walkdowns, it was noted that the High Pressure Coolant Injection (HPCI) room cooler was running with no change in room temperature. An Operator was dispatched to inspect the cooler and found that the drive belt had broken. The HPCI System was declared inoperable and a seven day Limiting Condition for Operation (LCO) was entered per Technical Specification 3.5. The Electrical Maintenance Department (EMD) replaced the drive belt per Nuclear Work Request 950037405-01. Additionally, the failed drive belt was sent to the Original Equipment Manufacturer (OEM) to determine the cause of failure. The LCO was terminated on April 17, 1995, at 2009 hours. The Safety Significance of this event is minimal since all other Emergency Core Cooling Systems (ECCS) required by TS 3.5.C.2.a were operable. A similar previous occurrence was reported by LER 89-022 on docket 050249 and LER 93-1 on docket 050249. This report is being submitted in accordance with 10CFR50.73(a)(2)(v)(D).

MONTH

06

EXPECTED SUBMISSION

DATE (15)

DAY

YEAR

95

U.S. NUCLEAR REGULATORY COMMISSION

PPROVED BY CMB NO. 3150-0104 EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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Dresden Nuclear Power Station, Unit 3		95	009	00	2 OF 4

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

EVENT IDENTIFICATION:

High Pressure Coolant Injection Declared Inoperable Due to Broken Room Cooler Drive Belt on Dresden Unit 3

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 3 Event Date: 04/16/95 Event Time: 1358

Reactor Mode: N Mode Name: RUN Power Level: 97%

Reactor Coolant System Pressure: 1002 psig

B. DESCRIPTION OF EVENT:

On April 16, 1995, at 1358 hours, with Unit 3 at 97% rated core thermal power, during Nuclear Station Operator (NSO) panel walkdowns, it was noted that the High Pressure Coolant Injection (HPCI) [BJ] room cooler was running with no change in room temperature. An Operator was dispatched to inspect the cooler and found that the drive belt had broken. The HPCI system was declared inoperable and a seven day Limiting Condition for Operation (LCO) was entered per Technical Specification (TS) 3.5. The EMD took immediate actions to install a new drive belt and adjust it to the proper tension requirements. Dresden Electrical Procedure (DEP) 5700-04, HPCI Room Fan Preventive Maintenance, was successfully completed. The HPCI system was returned to service and the LCO was terminated at 2009 hours on April 17, 1995. The safety significance of this event was determined to be minimal since the HPCI system remained capable of automatically initiating, and all other Emergency Core Cooling Systems (ECCS) required by TS 3.5.c.2 were operable.

C. CAUSE OF EVENT:

This report is being submitted in accordance with 10CFR50.73(a)(2)(v)(D), which requires the reporting of any condition that could have prevented the fulfillment of a safety system needed to mitigate the consequences of an accident. Although failure of the HPCI room cooler would not have defeated the design function of the HPCI system, the room cooler fans are required for recirculation of air in the event of a postulated design basis accident. Therefore, the system was declared inoperable.

The current motor mounting design is a result of an upgrade to the motor mount bracket. This was initiated, in part, to address the previous event when a belt broke, LER 93-17 on docket 050249. The previous design caused the belt pulleys to become misaligned, thus causing the belts to brake. The intent of the upgrade was to provide additional rigidity for the mounting of the motor to the HPCI room cooler external metal skin. The new mount significantly reduced the vibration experienced by the cooler. In addition, the conventional 'V' drive belt and pulleys were replaced with a toothed drive belt and sprocket. The current HPCI room cooler belt design parameters were reviewed, with no errors or oversights identified. The HPCI room cooler was inspected per DEP 5700-04, and no anomalies were found.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

Inspection of the failed belt showed no unusual wear, except at the point of failure. The OEM Representative stated that this may indicate a manufacturing problem, but further analysis would be required.

The apparent cause of the HPCI inoperability was due to the broken room cooler drive belt. The root cause of the broken drive belt has not been determined. The belt was sent to the OEM for analysis to determine the cause of failure.

D. SAFETY ANALYSIS:

The HPCI system is designed to pump water into the reactor vessel under loss of coolant conditions which do not result in rapid depressurization of the pressure vessel. The loss of coolant might be due to a loss of reactor feedwater or to a small line break which does not cause immediate depressurization of the reactor vessel. The anticipated operational requirements of the HPCI system is for less than four hours.

Although the HPCI system was declared inoperable, the automatic function of the HPCI system was not hindered. The HPCI system would still have been able to perform its function until the temperature of the room reached 175 degrees, during the event of a postulated accident. When 175 degrees is reached, the HPCI system would isolate on area high temperature, assuming a steam leak in the HPCI room. It was determined through engineering calculations (Nuclear Fuel Services Report RSA-D-92-06) that the room temperature would reach the HPCI isolation point after 19 hours with the fan running (without cooling water) and the initial room temperature of 120 degrees. During this event the initial room temperature was at 104 degrees. Through extrapolation, engineering judgment suggests that with the lower initial HPCI room temperature and without the fan running, the HPCI system would have been able to perform its function for a number of hours prior to reaching the isolation temperature.

However, the HPCI room cooler fans are required for circulation (without cooling water) during the event of a postulated accident. This analysis is documented in the Nuclear Fuel Services Report RSA-D-92-06. Additionally, all other Emergency Core Cooling Systems (ECCS) required by T.S. 3.5.c.2 were operable.

Therefore, for the above reasons, the safety significance of this event was considered minimal.

E. CORRECTIVE ACTIONS:

Nuclear Tracking System (NTS) tracking code numbers are identified in the text as (XXX-XXX-XXXXXX).

- The HPCI room cooler drive belt was replaced per NWR 950037405-01.
- The HPCI room cooler was inspected, per DEP 5700-04, prior to declaring the HPCI system operable and no anomalies were found.
- 3. The current HPCI room cooler drive belt design was reviewed with the OEM Representative and no errors or oversights were identified. (April 20, 1995)

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NRC FORM 366A (5-92).

.S. NUCLEAR REGULATORY COMMISSION

PROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95

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TEXT (If more space is required, use additional copies of NRC form 366A) (17)

- 4. The HPCI room cooler is being visually inspected (including the drive belt) on a weekly basis for indication of degradation. The inspections will continue pending determination of the root cause of the drive belt failure.
- 5. The HPCI room cooler belt was sent to the OEM for analysis to determine the cause of failure, if possible. The results and conclusions of the Manufacturer's analysis, including the impact of the frequency of HPCI room cooler start/stops on the drive belt and any additional corrective actions, will be provided in Supplement 1 to LER 95-009, docket 050249. (249-180-95-00901)

F. PREVIOUS OCCURRENCES:

LER/Docket Numbers

Title

89-022/050249

HPCI Inoperable Due to Broken Room Cooler Belts

The HPCI system was inoperable due to the failure of room cooler drive belts. The failure of the belts were attributed to increased frequency of cooler operation due to elevated HPCI room ambient temperatures.

93-017/050249

HPCI Declared Inoperable Due to Broken Room Cooler Drive

Belt

The HPCI system was inoperable due to the failure of room cooler drive belts. The failure of the belts were attributed to the poor design of the HPCI room cooler motor mount. The original motor mount supplied with the coolers was inadequately designed and as such, the belt pulleys were subject to misalignment. This condition led to premature belt failures.

G. COMPONENT FAILURE DATA:

Gates

Poly Chain

8M-1280-12 (catalog number)

The belt drive is not reportable to NPRDS.