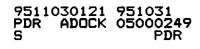
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	LICENSEE EVENT REPORT (LER) FORWARD COMMENTS REGARDING BURDEN ESTIMATE FORWARD COMMENTS REGARDING BURDEN ESTIMATE T THE INFORMATION AND RECORDS MANAGEMENT BRANC (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION WASHINGTON, DC 20555-0001, AND TO THE PAPERWOR REDUCTION PROJECT (3150-0104), OFFICE O MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.							50.0 HRS. TIMATE TO NT BRANCH							
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MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVIS		MONTH	DAY	YEAR	FACILIT None	ACILITY NAME		DOCKET NUMBER		
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			20.22	03(a)(2)(iii)			50.36(c)(2)			50.73(a)(2)(v	/iii)(A)			below
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

At approximately 2130, on June 30, 1995, with Unit 3 shutdown for maintenance, the performance of Dresden Technical Surveillance (DTS) 1600-01, Local Leak Rate Testing Of Primary Containment Isolation Valves, identified the Main Steam Line Drain (MSLD) gate valves 3-220-1 and 3-220-2 to be leaking more than the test equipment could measure. Closing of the 3-220-2 valve by means of manual engagement of the Motor Operated Valve's (MOV) handwheel resulted in valve internal damage and a leakage path. The gate valves were inspected, repaired or replaced and Local Leak Rate Tested (LLRT) prior to unit startup. This supplement is being submitted to report the cause(s) of the valve failures, safety significance, corrective actions taken and results of the as-left LLRT.



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NRC FORM 366A (5-92)	U.S. NUCLEAR R	EGULATORY COMMISSION		APPROVED BY EXPIR	ONB NO. 315 ES 5/31/95	0-0104
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EVENT IDENTIFICATION:

Leakage Limit Exceeded Due to Valve Internal Damage Caused by Manual Operation of MOV.

A. PLANT CONDITIONS PRIOR TO EVENT:

Unit: 3Event Date: 06/30/95Event Time: 2130Reactor Mode: NMode Name: ShutdownPower Level: 0%Reactor Coolant System Pressure: 0 psig

B. DESCRIPTION OF EVENT:

During Refuel Outage D3R13 (March 1994 - November 1994), the Main Steam Line Drain (MSLD) [SB] Primary Containment Isolation Valves 3-220-1 and 3-220-2, Crane gate valves, were cut out and replaced with Anchor Darling dual disk gate valves.

On January 16, 1995, with Unit 3 exiting Maintenance Outage D3F17, the MSLD inboard gate valve 3-220-1 was given a close signal. Dual indication (both open and closed), not a full close indication, was received in the Control Room. The valve was opened and again given a close signal. This time the Control Room received a full close indication. Since the indication was erratic, this Primary Containment Isolation Valve was declared inoperable.

Technical Specification 3.7.D.1. states:

During reactor power operation conditions, all primary containment isolation valves and all instrument line flow check valves shall be operable except as specified in 3.7.D.2.

Technical Specification 3.7.D.2. states:

In the event any primary containment isolation valve becomes inoperable, reactor power may continue provided at least one valve in each line having an inoperable valve is in the mode corresponding to the isolated condition.

Therefore, the MSLD outboard gate valve 3-220-2 was taken Out-of-Service in the closed position. This stopped the clock for the Limiting Condition for Operation described in Technical Specification 3.7.D.3. which states:

If specification 3.7.D.1 and 3.7.D.2 cannot be met, an orderly shutdown shall be initiated and the reactor shall be in the cold shutdown condition within 24 hours.

When Dresden Unit 3 shutdown for Maintenance Outage D3F18, the Motor Operated Valve (MOV) team began investigating the valve's position discrepancy. Limits were found to be engaged and the valve appeared to be closed. The torque switch setting was then increased in order to increase margin between the minimum required thrust and thrust developed at the torque switch setting. At approximately 2100, on June 14, 1995, the performance of Dresden Technical

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Surveillance (DTS) 1600-01, Local Leak Rate Testing Of Primary Containment Isolation Valves, identified the MSLD gate valves 3-220-1 and 3-220-2 to be leaking more than the test equipment could measure. Checking of the vent path revealed that the MSLD outboard gate valve 3-220-2 was leaking greatly. The Unit Supervisor was notified of the event and a Performance Improvement Form (PIF) was written. The ComEd Reportability Manual states:

In general, for the purpose of evaluating the reportability of situations found during surveillance tests, it should be assumed that the situation occurred at the time of discovery, unless there is firm evidence to believe otherwise.

On May 29, 1995, the High Pressure Coolant Injection (HPCI) System [SJ] check valve 3-2301-45 had leaked great enough to cause the cumulative Type B and C leakage to exceed the Technical Specification leakage limit of 0.60 L (488.452 standard cubic feet per hour). This failure was reported in LER/Docket 95-011/0500249. Reporting of the MSLD test volume LLRT failure was to be included in the supplement to that LER. However, the significance of the inboard valve failure described below required this report to be submitted.

On June 16, 1995, the MSLD test volume was pressurized and the outboard gate valve 3-220-2 was manually opened and then closed while the vent path was monitored. The leakage past the 3-220-2 was still unmeasurable. Valve disassembly revealed valve internal damage, a bent valve stem and valve internals missing. The Unit Supervisor was notified and a PIF (2492009506300) was written. An inspection of the piping with a boroscope did not locate the missing valve parts. Due to the internal damage suffered by the valve, the valve was cut out. To verify primary containment integrity, a plug was installed in the MSLD piping in order to Local Leak Rate Test the inboard gate valve 3-220-1.

At approximately 2130, on June 30, 1995, the performance of Dresden Technical Surveillance (DTS) 1600-01, Local Leak Rate Testing Of Primary Containment Isolation Valves, identified the Main Steam Line Drain (MSLD) gate valve 3-220-1 to be leaking more than the test equipment could measure.

The Unit Supervisor was notified of the event, and an ENS phone notification was then made at 0400 Eastern Standard Time on Saturday July 1, 1995 to report a condition that was outside of the design basis of the plant and a PIF was written to report a condition prohibited by the plant's Technical Specifications.

The MSLD test volume was again pressurized and the inboard gate valve 3-220-1 was manually opened and then closed while the leakage rate was monitored. The valve was left in the position where leakage was at its lowest rate, 17 scfh (standard cubic feet per hour).

A contact check of the disk and seating surfaces of the 3-220-1 valve determined that there were low spots on each side of the valve's outboard seat. Dresden Mechanical Procedure (DMP) 0040-58, Anchor Darling Dual Disk Gate Valve Maintenance, recently written to provide proper instructions for fit up of the valve disks, was used to correctly fit up the 3-220-1 and 3-220-2 valves after the performance of repairs. An as-left LLRT yielded a 0.10 scfh leakage rate.

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Due to the two MSLD valve failures coupled with knowledge of recent problems with this type of valve at other stations, Engineering determined that Local Leak Rate Testing of the other Anchor Darling dual disk gate valves was warranted. Other Crane gate valves which were replaced with Anchor Darling dual disk gate valves during Refuel Outage D3R13 are the Reactor Water Cleanup (RWCU) System [CE] suction valves 3-1201-1, 3-1201-1A and 3-1201-2 and the Reactor Head Spray System [BO] valve 3-205-24. These systems were taken Out-of-Service in order to be given an LLRT. The LLRT on the RWCU valves yielded a leakage which was too great to be measured by the test equipment. Trouble shooting determined that the excessive leakage was past the inboard valve 3-1201-1 and its bypass valve 3-1201-1A, and that the outboard valve 3-1201-2 was leaking 5 scfh. The LLRT of the Reactor Head Spray System gate valve 3-205-24 yielded a leakage of 1 scfh.

Light lapping was performed on the 3-1201-1A valve as the seat to disk revealed good contact. After disassembly of the 3-1201-1 valve, a check of seat to disk contact revealed a low spot in the seating surface. The 3-1201-1 valve had the seating surfaces lapped to repair the low spots on the valve's outboard disk and DMP 0040-58 was performed to ensure correct fit up. During the post-maintenance LLRT, the 3-1201-1 valve showed a leakage of 26 scfh which is higher than the administrative limit of 20 scfh. It was determined that due to radiological concerns it would be better to improve the leak rate during D3R14, since the impact to the overall containment leakage was minimal.

C. CAUSE OF EVENT:

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This LER is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B) which requires the reporting of any operation or condition prohibited by the plant's Technical Specifications.

This LER is also submitted pursuant to 10 CFR 50.73(a)(2)(ii) which requires reporting any event or condition that resulted in the condition of the nuclear power plant, including its principal safety barriers, being seriously degraded.

Disassembly of values 3-220-1 and 3-1201-1 determined improper fit up of the seating surfaces to be the cause of the leakage. Improper fit up was due to lack of experience with Anchor Darling value maintenance since these are new values, not installed anywhere else in the plant.

It was determined that the cause of damage to the 3-220-2 valve was excessive thrust being applied to the valve. It was determined that manual operation of the MOV handwheel was the cause of the over stress.

D. SAFETY ANALYSIS:

The safety significance of the leakage past the 3-1201-1 was considered to be minimal since the minimum pathway leakage through this containment penetration was 5 scfh past the outboard isolation valves 3-1201-2 and 3-1201-3 and would not have caused the maximum off-site dose rates established in 10 CFR 100 to be exceeded.

Additional Unit 3 Primary Containment Isolation Valves experienced leakage, therefore, a review of total containment leakage was performed to determine the safety significance of the total containment leakage. This leakage included

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leakage from the containment liner, containment head, downcomer, suppression pool, welds, valves, penetrations, piping and instrumentation. Assuming the worst case break of Main Steam Line Drain pipe in the Turbine Building, preliminary calculations using Station Off-site Dose Calculation Manual software for Control Room Operator dose Exclusion Area Boundary (EAB) dose, and Low Population Zone (LPZ) dose were performed based on minimum pathway leakage from the Dresden Unit 3 Primary Containment. Under worst case conditions, dose limits for Control Room Operators established by General Design Criteria (GDC) 19 of Appendix A to 10 CFR 50 as well as EAB and LPZ dose limits established by 10 CFR 100 would have been exceeded during the Design Basis Accident.

However, the purpose of the Main Steam Line Drains is to collect moisture in the Main Steam Lines and direct it to the Main Condenser. Hence, this line exits the containment, traverses the Reactor Building, enters the Turbine Building (i.e. exits Secondary Containment which is filtered by the Standby Gas Treatment System) ultimately ending up at the Main Condenser. This non-safety related line is not expected to break during the Design Basis Accident and leakage past the MSLD valves is expected to get held up/contained in the Main Steam Lines and Main Condenser. Additional evaluations are being performed to refine the dose rate calculations to determine whether or not either GDC 19 limits or 10 CFR 100 limits would have been exceeded. This event is significant due to the potential for release of radioactivity to the public due to total containment leakage, however, the safety significance of the leakage from Primary Containment is considered to be minimal because there was no challenge to containment and no release.

E. CORRECTIVE ACTIONS:

Dresden Mechanical Procedure (DMP) 0040-58, Anchor Darling Dual Disk Gate Valve Maintenance, is in use to provide proper instructions for fit up of valve disks to seats.

Dresden Administrative Procedure (DAP) 03-05, Out-of-Service and Personnel Protection Cards, was revised to formally control handwheel usage during out-ofservice placements and to note the potential to invalidate LLRTs when the MOV is operated manually.

DAP 07-27, Independent Verification, was revised to include the proper technique for verifying a MOV closed to prevent unnecessary handwheel operation.

Additional evaluations are being performed to refine the dose rate calculations to determine whether or not either GDC 19 limits or 10 CFR 100 limits would have been exceeded (NTS 249-180-95-00704).

F. PREVIOUS OCCURRENCES:

LER/Docket Numbers Title

None associated with Anchor Darling dual disk gate valves.

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G. COMPONENT FAILURE DATA:

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Manufacturer	Nomenclature	Model Number	Mfg. Part Number
Anchor Darling Valve Co.	MSLD 3-220-1 3-220-2	DD	N/A
	RWCU 3-1201-1 3-1201-1A	DD	N/A

An industry - wide data base search revealed 148 corrective maintenance entries for the Anchor Darling Model DD dual disk gate valve. Five failures were attributed to internal valve damage or misalignment of valve internals.