



Commonwealth Edison

One First National Plaza, Chicago, Illinois
Address Reply to: Post Office Box 767
Chicago, Illinois 60690

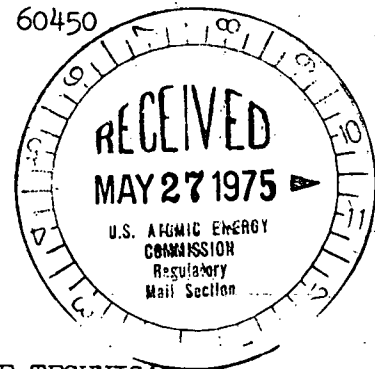
Regulatory

File No.

BBS Ltr. #320-75

Dresden Nuclear Power Station
R. R. #1
Morris, Illinois 60450
May 21, 1975

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



SUBJECT: REPORT OF ABNORMAL OCCURRENCE PER SECTION 6.6.A OF THE TECHNICAL SPECIFICATIONS UNIT-2 DIESEL GENERATOR OVERHEATED

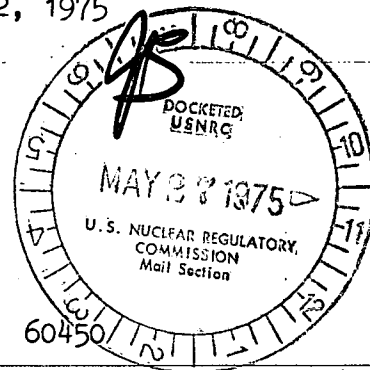
- References:
- 1) Regulatory Guide 1.16 Rev. 1 Appendix A
 - 2) Notification of Region III of U. S. Nuclear Regulatory Commission
Telephone: P. Johnson, 1510 hours on May 11, 1975
Telegram: J. Keppler, 1405 hours on May 12, 1975
 - 3) Drawing Number M173

Report Number: 50-237/1975-23

Report Date: May 21, 1975

Occurrence Date: May 11, 1975

Facility: Dresden Nuclear Power Station, Morris, Illinois 60450



IDENTIFICATION OF OCCURRENCE

The Unit-2 diesel generator overheated after an inadvertent fast start. The removal of a RPS/ECCS-instrument-line-check valve-upset level instruments initiating ECCS. The diesel generator failure could have prevented the intended function of an engineered safety feature system.

CONDITIONS PRIOR TO OCCURRENCE

Unit-2 was in the cold shutdown mode during an extended refueling outage.

DESCRIPTION OF OCCURRENCE

At approximately 0645 hours on May 11, 1975, an instrument flow check valve was dismantled, causing the loss of one leg of a Yarway level indicator. This

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deficiency initiated the Unit-2 Emergency Core Cooling System. The Unit-2 diesel generator started but overheated due to lack of cooling water.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE (Operator/Equipment)

The inadvertent initiation of the ECCS occurred because the effect of valving out flow check valve 2-263-2-15A had not been adequately investigated.

The diesel generator overheated because its cooling water pumps lost suction. Traveling screens C and D were out of service for an electrical control modification and consequently were blocked. A differential pressure instrument on the traveling screens was inoperable, preventing the high differential pressure alarm from actuating.

ANALYSIS OF OCCURRENCE

This occurrence in no way jeopardized the health and safety of the public. Unit-2 was in cold shutdown and no work was being done that potentially endangered safe reactor coolant level.

CORRECTIVE ACTION

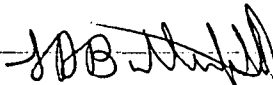
The diesel generator was immediately taken out of service and inspected for damage. Work was also initiated to correct the problems with the traveling screens and differential pressure switch.

The station is reviewing improvements in the crib house operator rounds to help detect problems with the traveling screens and their controls. This review is scheduled for completion by June 15, 1975.

FAILURE DATA

Failure of the diesel generator due to this particular sequence of events has never occurred before.

Sincerely,



B. B. Stephenson
Superintendent

BBS:JBM:amp

File/NRC