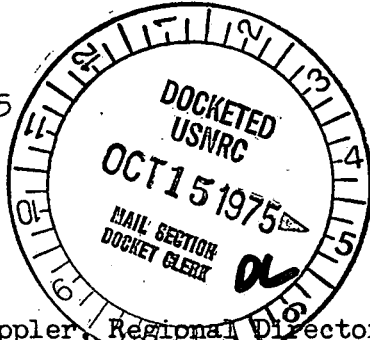




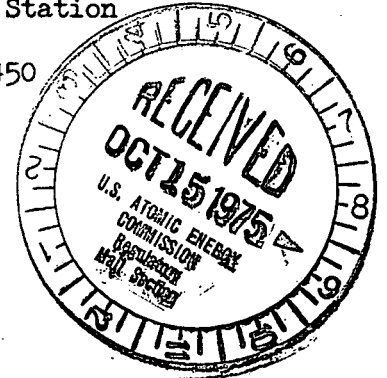
**Commonwealth Edison**  
 One First National Plaza, Chicago, Illinois  
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**Regulatory Docket File**

BBS Ltr. #673-75



Dresden Nuclear Power Station  
 R. R. #1  
 Morris, Illinois 60450  
 October 9, 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 REACTOR SCRAM ON DRYWELL OVER-PRESSURIZATION

- References:
- 1) Regulatory Guide 1.16 Rev. 1 Appendix A
  - 2) Notification of Region III of U. S. Nuclear Regulatory Commission  
 Telephone: P. Johnson, 1150 hours on September 29, 1975  
 Telegram: J. Keppler, 1310 hours on September 29, 1975
  - 3) Drawing Number M-25

Report Number: 50-237/75-46

Report Date: October 9, 1975

Occurrence Date: September 29, 1975

Facility: Dresden Nuclear Power Station, Morris, Illinois

IDENTIFICATION OF OCCURRENCE

The Unit-2 reactor scrambled on high drywell pressure during the drywell inerting process.

CONDITIONS PRIOR TO OCCURRENCE

Unit-2 was in the run mode at a power level of 1055 MWt and 303 MWe.

DESCRIPTION OF OCCURRENCE

During the process of inerting the primary containment atmosphere, the pressure in the containment reached the high drywell pressure scram setpoint, and the reactor scrambled at 0524 hours on September 29, 1975.

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DESIGNATION OF APPARENT CAUSE OF OCCURRENCE (Operator Error)

The drywell over-pressurization apparently resulted from a valving error which occurred during clearing of the previous weekend outage. Manual valve 8502-501 was partially opened, allowing nitrogen flow to bypass the inerting pressure control valve and pass directly into the drywell.

ANALYSIS OF OCCURRENCE

This occurrence did not threaten the safety of plant personnel or the general public. Upon sensing high drywell pressure, the unit scrambled satisfactorily, with all Emergency Core Cooling System (ECCS) equipment functioning as required.

CORRECTIVE ACTION


After receiving the high drywell pressure alarm, the NSO immediately verified the inerting pressure control valve to be closed. A shift foreman and operator were dispatched to the torus area to check valving and found manual bypass 8502-501 to be partially open. The valve was immediately closed.

A sample of the drywell atmosphere was obtained for analysis. No unusual activity was noted, and the drywell was vented to the Standby Gas Treatment System. All Emergency Core Cooling systems were returned to the normal mode, with the exception of HPCI which failed to trip (see report no. 50-237/75-45).

A task force was assembled to study the problem and take corrective action. The following corrective actions were completed:

- 1) A lock and chain were installed to lock the manual bypass valve in the closed position.
- 2) Procedures were revised to clarify valve checklists; the valve checklist was revised to include locking manual bypass valve.
- 3) To avoid operator confusion, correct valve tagging was verified to correspond to valve checklist.
- 4) A local leak-rate test was performed on the volume bounded by valves AO-2-1601-21, -22, -55, -56, and manual bypass 2-8502-501, with satisfactory results.

Operators were cautioned to verify proper valve numbers when taking valves out of service as well as when clearing outages. A locked-valve checklist for Unit-2 is being prepared to ensure that errors of this nature do not recur.

  
B. B. Stephenson  
Superintendent

BBS:JSK:smp

File/NRC