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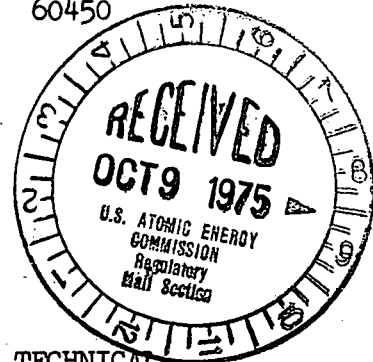
BBS Ltr. #655-75

Dresden Nuclear Power Station
 R. R. #1
 Morris, Illinois 60450
 October 2, 1975

Regulatory

File Copy

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 FAILURE TO START

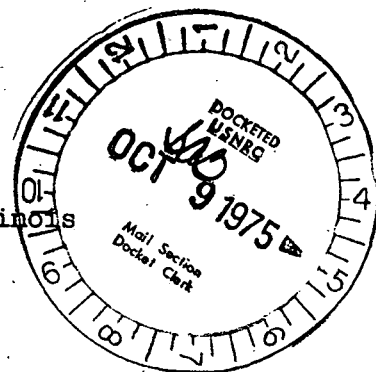
- References:
- 1) Regulatory Guide 1.16 Rev. 1 Appendix A
 - 2) Notification of Region III of U. S. Nuclear Regulatory Commission
 Telephone: P. Johnson, 1420 hours on September 23, 1975
 Telegram: J. Keppler, 1505 hours on September 23, 1975
 - 3) Drawing Number M173

Report Number: 50-237/75-244

Report Date: October 2, 1975

Occurrence Date: September 23, 1975

Facility: Dresden Nuclear Power Station, Morris, Illinois



IDENTIFICATION OF OCCURRENCE

The Unit-2 diesel generator failed to start.

CONDITIONS PRIOR TO OCCURRENCE

Unit-2 was in a steady-state condition at a power level of 1576 MWt and 490 MWe. The Unit-2 diesel generator was being tested to demonstrate operability for a Unit 2/3 diesel generator outage.

DESCRIPTION OF OCCURRENCE

At approximately 0230 hours on September 23, 1975, the Unit-2 diesel generator failed to turn over during starting. The pinion gears of the air starting motors engaged properly, but the main air relay valve failed to open, blocking the driving air pressure from the starting motors.

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Immediately following the initial attempt, the diesel generator was successfully started three consecutive times.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE (Operator Error)

The apparent cause of the occurrence was the failure to follow the monthly diesel generator inspection procedure and quality control procedures for replacement of safety related components. The valve was disassembled during a routine monthly inspection rather than during the extensive annual inspection. The seal ring was replaced with a ring that was not specifically a replacement part. The improper seal ring was responsible for the sluggish operation of the valve.

ANALYSIS OF OCCURRENCE

This occurrence did not threaten public health and safety. Had an accident condition developed, off-site power as well as the Unit 2/3 diesel generator would have been available to supply necessary emergency equipment.

CORRECTIVE ACTION

The diesel generator was removed from service, and the entire air start system was inspected for obstructions. The air relay valve was subsequently dismantled, and the sticking seal ring was replaced with the proper component. Upon reassembly, the valve was operated satisfactorily several times. The diesel generator has been started at least three times since the valve was re-installed. No starting difficulties have been noted.

The importance of adhering to the monthly diesel-generator inspection procedure and quality control procedures will be reemphasized to the maintenance department. In addition, storeroom control of the proper replacement seal will be established to prevent a similar occurrence.


B. B. Stephenson
Superintendent

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