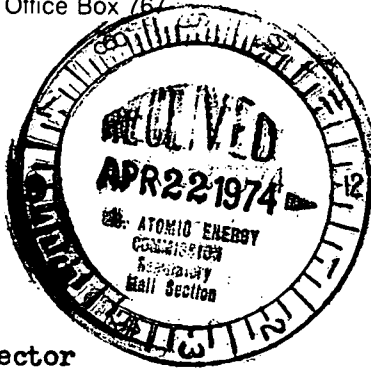




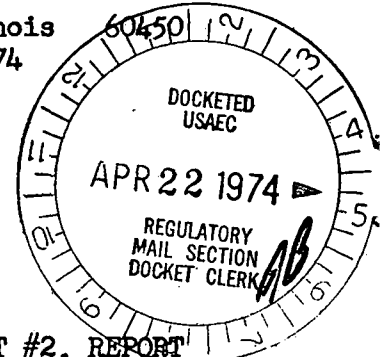
**Commonwealth Edison**  
One First National Plaza, Chicago, Illinois  
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Chicago, Illinois 60690

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BBS Ltr. #289-74



Dresden Nuclear Power Station  
R. R. #1  
Morris, Illinois  
April 18, 1974



Mr. J. F. O'Leary, Director  
Directorate of Licensing  
U. S. Atomic Energy Commission  
Washington, D. C. 20545

SUBJECT: LICENSE DPR-19, DRESDEN NUCLEAR POWER STATION, UNIT #2, REPORT OF ABNORMAL OCCURRENCE PER SECTION 6.6.B.1.a OF THE TECHNICAL SPECIFICATION. PRESSURE SUPPRESSION CHAMBER TO DRYWELL VACUUM BREAKERS INOPERABILITY DURING MAINTENANCE.

- References: 1) Notification of Region III of AEC Regulator Operations  
Telephone: Mr. Fishbaugher, 1515 hours on April 11, 1974.  
Telegram: Mr. Keppler, 1615 hours on April 11, 1974.
- 2) Dwg: P & ID M-25

Dear Mr. O'Leary:

This letter is to report a condition relating to the operation of the unit at about 1530 hours on April 10, 1974. At this time, during routine plant surveillance, it was noted that four (4) of the twelve (12) pressure suppression chamber to drywell vacuum breakers were wired closed. This condition is contrary to section 3.7.4.a of the Technical Specifications which requires that whenever primary containment is required at least nine (9) of the twelve (12) drywell-pressure suppression chamber vacuum breakers be operable.

PROBLEM

On April 5, 1974 at 0820 hours Unit #2 was operating at steady state conditions with reactor power at 2135 MW<sub>t</sub> and a load of 705 MW<sub>e</sub>. The maintenance department was modifying the pressure suppression chamber to drywell vacuum breakers. The valve lever arms were being rotated to adjust closing torque and position switches relocated to reflect the new lever arm position. During routine plant surveillance at approximately 1530 hours April 10, 1974 it was noted that four (4) vacuum breakers were wired closed. This condition was immediately reported to the operating and maintenance departments, and by 1600 hours one of the valves had the wire securing it in the closed position removed, which corrected the condition and brought the unit into compliance with the Technical Specifications.

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INVESTIGATION

Work on Unit #2 vacuum breakers began April 4, 1974. The work consisted of rotating the vacuum breaker lever arms to a position of 10° from the upright vertical position to increase the closing torque and repositioning the limit switches to annunciate the "Torus Vacuum Breaker Valves Open" alarm when the valve is off its normal position. The operating department informed the maintenance department that a maximum of three valves could be removed from service at one time per the Technical Specifications. They were also cautioned that one vacuum breaker (1601-33C) had been taken out of service and wired closed last December 5, 1973. The foreman who ran the job, however, was not made aware of this one valve. Consequently, he proceeded to wire one valve closed on April 4 and two more on April 5. This made four valves wired closed. This condition remained until April 10 when it was discovered and corrected.

CORRECTIVE ACTION

The corrective action in this case was to unsecure one valve and thus work on only two at a time. To preclude this situation from occurring in the future a procedure will be written to visually inspect all twelve vacuum breakers prior to removing from service or securing in the closed position. This new procedure will be complied with immediately and a formal procedure written within 60 days.

EVALUATIONS

This condition did not affect the safe operation of the plant. This statement is based on a fact listed in the Safety Analysis Report. Page 5.2-11 states, "The vacuum breaker capacity selected on this test basis is more than adequate (typically by a factor of four) to limit the pressure differential between the suppression chamber and drywell during post-accident drywell cooling operations to a value which is within suppression system design values. Based on this excerpt, the plant personnel and the public were not endangered.

This is the first time this situation has occurred and with the described corrective action the station feels the resolution and evaluation are adequate and does not require any further action.

Sincerely,

*B B Stephenson* AR

B. B. Stephenson

BBS:MST:smp