Commonwealth Edison
Dresden Nuclear Power Station
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July 9, 1985

DJS Ltr #85-720

James G. Keppler
Regional Administrator
Director of Inspection and Enforcement
Region III
U.S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Reference: 1) DJS Ltr. 85-449 to J.G. Keppler from D.J. Scott dated 5/16/85
2) DJS Ltr. 85-653 to J.G. Keppler from D.J. Scott dated 6/12/85

Dear Sir:

This letter is in reference to Confirmatory Action Letter 85-04 regarding the Main Steam Line Snubber Monitoring System for Dresden Unit 2. Item 2 of this Confirmatory Action Letter requires a verbal notification to Region III within 2 working days followed by a written report and safety evaluation within 30 calendar days.

Four occurrences have been identified during this reporting period. They are:

Occurrence #7 Notification made to D. Danielson by J. Achterberg on 6/14/85.

Occurrence #8 Notification made to D. Danielson by J. Achterberg on 6/20/85.

Occurrence #9 Notification made to I. Yin by J. Achterberg on 6/21/85 during site visit.

Occurrence #10 Notification made to D. Danielson by J. Achterberg on 7/8/85.

The written report and safety evaluation for each occurrence is attached. Occurrence #2 reported on 5/16/85 has been updated to include additional information.

Sincerely,

D.J. Scott
Station Manager
Dresden Nuclear Power Station

DJS/JA/kjl
Attachment
cc: J. Almer
W. Pierce
B. Schroeder
File/Numerical
J. Achterberg
J. Brunner
File/NRC

IE 36

Occurrence #2 (Update)

Previously it was reported that snubber #46 strain gage failed to perform properly. The instrument output became very erratic and subsequently failed. A meeting was held (with NRC, I. Yin present) to analyze the problem and determine what actions should be taken. It was agreed upon that unit operation could continue until the next scheduled outage at which time an investigation would be conducted to determine the root cause of the failed strain gage.

On May 9, 1985 Unit 2 was shutdown due to a problem which developed with the 2B recirc pump M-G set. It was decided that the 62 day snubber inspection could be performed since this shutdown was within the 62 day $\pm$ 25% criteria as stated in the Technical Specification section 3.6.I/4.6.I.

A visual inspection was performed on all steam line snubbers including the snubbers on the Targetrock relief valve and Electromatic relief discharge lines. In addition, snubber #17 (recirc ring header) and #1527 (LPCI D/W spray) were also inspected. Additional inspections of the structural steel supports were conducted by Sargent & Lundy. Wyle Lab representative assisted in the analysis of snubber #46 strain gage instrument failure.

The results of all the inspections found only that the spherical bearing on snubber #46 had slipped approximately 3/16" out of position. The cause was attributed to inadequate peening/staking during the manufacturing process. Normal pipe vibration caused the bearing to slide out-of-place due to the weight of the snubber and the extension. This caused the strain gage to be crushed/pinched between the snubber yoke and anchor clevis thus rendering this sensing instrument inoperative. No other abnormalities were noted by S & L, Tech Staff, or Wyle Labs.

The spare instrument (located on snubber #45) was moved into snubber position #46 (and vice versa). The spare strain gage instrumentation was connected, however, it failed to operate. Only the LVDT remained operational on snubber #46. All other instrumentation will continue to monitor snubber performance.

Occurrence #7 (6/13/85)

On 6/13/85 Dresden Unit 2 began a normal unit startup following a brief outage which was caused by problems with the 2B recirculation pump (6/9/85). During the unit startup several snubber instrumentation monitor actuations were noted. After reviewing the sequence of events during the startup it was determined that the snubber instrumentation triggers occurred during the withdrawal of the source range monitors (SRM's) and the intermediate range monitors (IRM's). Again these traces were compared to those obtained during testing on 6/3/85 which is described in Occurrence #5 and were found to be similar in magnitude and duration. Therefore this event is believed to have been caused by electrical interference generated from the movement of the SRM's and IRM's.

Occurrence #8 (6/19/85)

On 6/19/85 Unit 2 scrammed from a scram discharge volume hi hi level. The high level in the scram discharge volume was caused by a leaking scram outlet valve on control rod drive J-6. Immediately following the scram the snubber instruments responded several times. The pulses were of such magnitude and short duration that it was concluded they were caused by electrical interference from the operation of nearby equipment and valve actuations in the drywell. These traces were compared to those generated following a scram on 5/18/85 (Occurrence #4) and were found to be similar. All snubber indications returned to normal values.

Occurrence #9 (6/20/85)

During Unit startup following a reactor scram (Occurrence #8) several snubber instrumentation monitor actuations were noted. The snubber instrumentation triggers occurred during the withdrawal of the SRM's and IRM's. These traces were compared to those obtained during testing on 6/3/85 which is described in Occurrence #5 and were found to be similar in magnitude and duration. Therefore, Dresden Station believes these traces were caused by electrical interference generated from the movement of the SRM's and IRM's.

Occurrence #10 (7/4/85)

Dresden Unit 2 was operating at 782 MWe and holding steady load. The snubber instrumentation triggered at 2001 hours. A review of the operating logs showed that no operational transients were occurring at that time. The instrumentation for snubber #52, which is located on the D main steam line, was the only instrument which triggered. The resulting trace is a single pulse of magnitude between 15 kips and 20 kips that rose from 0 to signal level and back to 0 within .02 seconds. Based on the short duration of time for the application and relaxation of the load and the fact that snubber #53, which is also located on D main steam line, showed no signs of a load it is believed that this event was caused by electrical interference.

The safety significance of these occurrences is minimal since there is no evidence of actual loads on the main steam line snubbers. Confirmation of this will be made by a visual inspection during snubber inspection required by the Technical Specifications.