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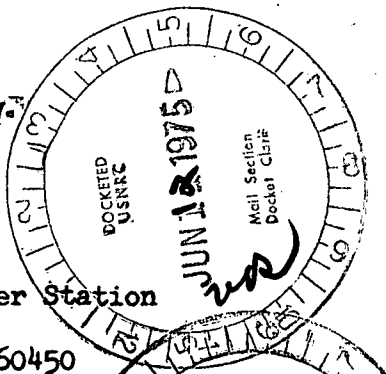
Regulatory File Cy.



BBS Ltr. #347-75

Dresden Nuclear Power Station
R. R. #1
Morris, Illinois 60450
June 5, 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 TORUS LOW LEVEL

References: 1) Regulatory Guide 1.16 Rev. 1 Appendix A

2) Notification of Region III of U. S. Nuclear Regulatory Commission
Telephone: Mr. P. Johnson, 1600 hours on May 27, 1975
Telegram: Mr. Keppler, 0815 hours on May 27, 1975

3) Drawing Number: P & ID M-29

Report Number: 50-237/1975-33

Report Date: June 5, 1975

Occurrence Date: May 26, 1975

Facility: Dresden Nuclear Power Station, Morris, Illinois

IDENTIFICATION OF OCCURRENCE

At 1700 hours on May 26, 1975, the torus level was found to be -6".

CONDITIONS PRIOR TO OCCURRENCE

Prior to the occurrence, unit-2 was in a steady-state condition at 742 MWt and 206 MWe.

DESCRIPTION OF OCCURRENCE

Because control room torus level indication was unreliable, visual inspections of a sight glass at the torus were being made once per shift. At 1700 hours on May 26, 1975 the level was found to be -6".

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DESIGNATION OF APPARENT CAUSE OF OCCURRENCE (Procedural violation)

The apparent cause of the occurrence was the failure of station personnel to follow procedures. The first violation occurred when a "B" operator was unable to find LPCI header vent valves 2-1501-43B & 45B which had been tagged out-of-service during an outage. The operator assumed that the OOS cards had either never been attached or were previously removed. The error was not caught, and the outage was subsequently cleared.

During LPCI system checks prior to start-up, valves 2-1501-43B & 45B were supposed to be used to vent the system drywell spray header. Another "B" operator was assigned this job. Apparently the operator inadvertently used the wrong valves because the two OOS cards again were not discovered. This error left the LPCI header vent valves open with an impending unit startup. When the ECCS jockey pump was started, water was pumped to the floor drain at the rate of approximately 30 gpm.

ANALYSIS OF OCCURRENCE

The health and safety of plant personnel and the public were not jeopardized by this occurrence. In comparison to the system flow capability, the water volume lost through the 3/4" header vent line was very small. A torus level of -6" represented a deviation of only 1/2" from Technical Specification limits. Given the conservative pressure and temperature calculations for the torus, the loss of 1/2" would not have affected the ability of the torus to perform in an emergency.

CORRECTIVE ACTION

The immediate corrective action was to start pumping water from condensate storage into the torus via the HPCI minimum flow line. At 1915 hours on May 26, torus level was at -5". By 0020 hours on May 27, the level was -3". During this time an investigation was underway to determine the cause of the problem. Heat exchanger tube leaks were suspected, as well as the piping line-up used earlier to pump water from the torus to the condenser. During the morning of May 27, valves 2-1501-43B & 45B were found open with the OOS cards still attached. The valves were closed and the torus level promptly stabilized.

The importance of following OOS card tagging procedures has been re-emphasized to the operators involved. In addition, the OOS card tagging procedure is presently being revised to facilitate the accountability of OOS cards.

E. B. Stephenson
Superintendent

BBS:smp
File/NRC