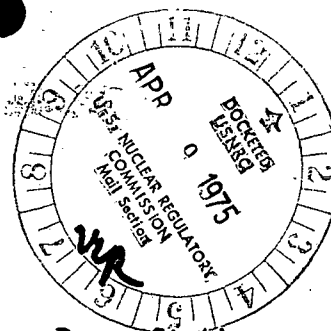




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Regulatory



BES Ltr. #207-75

Dresden Nuclear Power Station  
 R. R. #1  
 Morris, Illinois 60450  
 March 31, 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 VIOLATION OF SECONDARY CONTAINMENT**

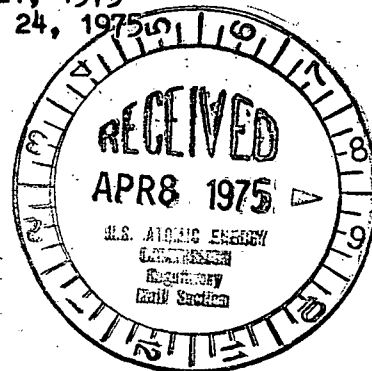
- References: 1) Regulatory Guide 1.16 Rev. 1 Appendix A  
 2) Notification of Region III of U. S. Nuclear Regulatory Commission  
 Telephone: P. Johnson 1615 hours on March 21, 1975  
 Telegram: J. G. Keppler 1355 hours on March 24, 1975

Report Number: 50-237/1975-19

Report Date: March 31, 1975

Occurrence Date: March 21, 1975

Facility: Dresden Nuclear Power Station, Morris, Illinois



**IDENTIFICATION OF OCCURRENCE**

On March 21, 1975 at approximately 1515 hours, secondary containment integrity was violated for approximately three minutes. This represents a limiting condition for operation as established in Section 3 of the technical specifications.

**CONDITIONS PRIOR TO OCCURRENCE**

Prior to the occurrence, Unit 2 reactor was locked in the shutdown mode with primary containment broken. On Unit 3, the reactor was in the run mode with steady power of 1270 MWt at a load of 400 MWe.

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DESCRIPTION OF OCCURRENCE

At 1515 hours on March 21, 1975, Unit 2 was shutdown for its third refueling outage. During the time of the occurrence, an engine driven Pettibone Crane was supporting outage work in the reactor building trackway area. In the same area, a personnel interlock door exists between the Unit 2 reactor building, outside atmosphere and the U 2/3 Diesel Generator room. Due to the large number of off site personnel involved in the present refueling outage, a security guard is on duty at this interlock door at all times.

With the crane engine exhausting fumes into the trackway, the guard became concerned because his assigned station was in close proximity to the crane. In accordance with proper procedures, the guard requested permission to open the drywell doors for additional ventilation. Permission was granted by an operating shift foreman. The guard then proceeded to open the interlock doors between the reactor building and the outside, thus violating secondary containment.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE (Personnel Error)

In reviewing this situation, it appears there was a misunderstanding between the security guard and the shift foreman. The misunderstanding stems from two sources: 1) The security guard's lack of proper component identification and 2) the shift foreman not questioning the request considering the short span of time that the guards have been working at the station.

ANALYSIS OF OCCURRENCE

The occurrence did not significantly jeopardize the safety of the general public, plant personnel nor the plant components. The doors were estimated to have been open between 3 to 5 minutes. In addition, the entrance was guarded from unauthorized entry at all times during this span of time.

CORRECTIVE ACTION

The maintenance foreman, who was responsible for the work area returned to the area and immediately reclosed the interlock doors.

As a result of the above occurrence, it will be explained to the security force that proper identification of components is most important when talking to operating personnel. Efforts will be made to make the guard force more familiar with the physical layout of the station. Due to the large size of the guard force this will be done on an informal basis.

FAILURE DATA

To date, no previous occurrences of this nature have been experienced.

  
B. B. Stephenson  
Superintendent

BBS:GR:smp

File/NRC