U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-237/86024(DRP); 50-249/86029(DRP)

Docket Nos. 50-237; 50-249 Licenses No. DPR-19; DPR-25

Licensee: Commonwealth Edison Company
P. O. Box 767
Chicago, IL 60690

Facility Name: Dresden Nuclear Power Station, Units 2 and 3

Inspection At: Dresden Site, Morris, Illinois

Inspection Conducted: September 30 thru December 2, 1986

Inspectors: L. G. McGregor
E. A. Hare
P. D. Kaufman

Approved By: ~~I. N. Jackiw~~, Chief
Projects Section 2D

12-15-86
Date

Inspection Summary

Inspection during the period of September 30 thru December 2, 1986 (Reports No. 50-237/86024(DRP); No. 50-249/86029(DRP))
Areas Inspected: Routine unannounced resident inspection of operational safety, followup of events, maintenance, surveillances, licensee event reports and I.E. Bulletins.
Results: Of the six areas inspected, no violations or deviations of NRC requirements were identified.

## DETAILS

1. Persons Contacted

Commonwealth Edison Company

*N. Kalivianakis, Division Vice President
*E. Eenigenburg, Station Manager
*J. Wujciga, Production Superintendent
*R. Flessner, Services Superintendent
T. Ciesla, Assistant Superintendent, Planning
R. Zentner, Assistant Superintendent, Maintenance
J. Brunner, Assistant Superintendent, Technical Services
R. Christensen, Unit 1 Operating Engineer
J. Almer, Unit 2 Operating Engineer
*J. Kotowski, Assistant Superintendent, Operations
W. Pietryga, Unit 3 Operating Engineer
J. Achterberg, Technical Staff Supervisor
*D. Adam, Compliance Administrator
J. Doyle, Q.C. Supervisor
D. Sharper, Waste Systems Engineer
E. O'Connor, Radiation Chemistry Supervisor
J. Mayer, Station Security Administrator
W. Johnson, Chemistry Supervisor
D. Saccomando, Radiation Protection Supervisor
M. Jeisy, Q.A. Supervisor
*R. Stols, Q.A. Inspector
H. Cobbs, Q.A. Inspector

The inspectors also talked with and interviewed several other licensee employees, including members of the technical and engineering staffs, reactor and auxiliary operators, shift engineers and foremen, electrical, mechanical and instrument personnel, and contract security personnel.

*Denotes those attending the final exit interview conducted on December 2, 1986 and one or more informal interviews at various times throughout the inspection period.

2. Operational Safety Verification

The inspectors observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the period from September 30 through December 2, 1986. The inspectors verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of Units 2 and 3 reactor buildings and turbine buildings were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance.

The inspectors witnessed the Unit 3 High Pressure Coolant Injection (HPCI) Pump Test which was conducted to Procedure DOS 2300-3, Revision 13. The test was performed to take vibration measurements on the HPCI pump rotor. Measurements were taken by the licensee's tech staff on the number 2 and 3 bearings. The data obtained will be analyzed and used as a preventative maintenance measure to preclude bearing failures.

The inspectors, by observation and direct interview, verified that the physical security plan was being implemented in accordance with the station security plan.

The inspectors observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. During the inspection, the inspectors walked down the accessible portions of the systems listed below to verify operability by comparing system lineup with plant drawings, as-built configuration or present valve lineup lists; observing equipment conditions that could degrade performance; and verified that instrumentation was properly valved, functioning, and calibrated.

The inspectors reviewed new procedures and changes to procedures that were implemented during the inspection period. The review consisted of a verification for accuracy, correctness, and compliance with regulatory requirements.

The inspectors also witnessed portions of the radioactive waste system controls associated with radwaste shipments and barreling.

These reviews and observations were conducted to verify that facility operations were in conformance with the requirements established under Technical Specifications, 10 CFR, and administrative procedures.

The following systems were inspected:

Unit 2

Low Pressure Coolant Injection System
Core Spray System

Unit 3

Isolation Condenser
High Pressure Coolant Injection System

Common

2/3 Emergency Diesel Generator
Standby Gas Treatment System

No violations or deviations were identified in this area.

3. Followup of Events

During the inspection period, the licensee experienced several events, some of which required prompt notification of the NRC pursuant to 10 CFR 50.72. The inspectors pursued the events onsite with the licensee and/or other NRC officials. In each case, the inspectors verified that the notification was correct and timely, if appropriate, that the licensee was taking prompt and appropriate actions, that activities were conducted within regulatory requirements and that corrective actions would prevent future recurrence. The specific events are as follows:

a. Unit 3 - At 8:15 a.m., on October 14, 1986, while operating at 100% power, a reactor scram occurred. A contractor decontaminating in the area of the main steam flow sensing lines, jarred the sensing lines and caused an erroneous high steam flow signal (120%) in the "A" main steam line. This resulted in a Group I isolation and closure of the MSIV's. Following the Group I isolation, the isolation condenser system was manually initiated at approximately 1010 pounds to control reactor pressure by throttling of the MO 3-1301-3 valve by the Unit Operator. During this manual valve operation, the operator turned the control switch for Valve MO-3-1301-3 to the "close" position. Thus, the isolation condenser system was isolated from the automatic initiation signal. As a result, electromatic relief Valve (ERV) 3-203-3B opened when reactor pressure reached 1080 psig and remained open for 38 seconds until reactor pressure decreased to 1035 psig. The setpoint pressure for the ERV is 1101 psig plus or minus 1 percent. Since the relief valve opened premature and outside the allowable setpoint error defined in Technical Specification 4.6.E, a drywell entry was made to check/calibrate the pressure switch on 3-203-3B ERV. The pressure switch error has been attributed to setpoint drift. The setpoint was readjusted to 1101 psig and successfully tested per DIS 250-3. The licensee tested the remaining ERV's (3-203-3C, D, and E) and target rock relief valve (3-203-3A) and found them to open within the allowable setpoints. The unit went critical on October 16, 1986 at 11:15 p.m., and the turbine was tied to the grid at 9:13 a.m. on October 17, 1986, after the above problems were corrected and the investigations, testing, calibrations, and surveillances completed.

b. Unit 3 - On October 14, 1986, while the unit was shutdown and the reactor vessel depressurized following a reactor scram earlier in the day, a Group V (isolation condenser) containment isolation signal was received at 8:50 p.m. in the control room. The licensee believes the spurious signal may have been caused when the inner door to the drywell was closed a little harder than normal resulting in the "jarring" of an instrument rack near the door. This jarring may have actuated the isolation condenser condensate high flow/high steam flow relays resulting in the Group V isolation signal. All the ISCO instrument setpoints were checked and were within their

Technical Specification limits. Attempts to repeat the spurious signal by slamming the interlock door were unsuccessful. The licensee has initiated an Action Item Record (AIR No. 12-86-35) to investigate and determine the cause of this event. The licensee will issue a supplemental report to Reportable Occurrence 86-018-00 on Docket 050249.

c. Unit 3 - On November 10, 1986 at 1:47 p.m., while operating at 98% power, a reactor scram occurred due to an Instrument Mechanic (IM) lifting incorrect power leads in a control room panel. The IM was in the process of replacing the Shutdown Cooling Temperature Recorder (3-1040-2) per Work Request (WR-56657) in the 903-4 Control Room panel. The IM removed wires from the wrong side of terminal block AA98 and 99 inside the 903-4 panel. The power leads which were incorrectly lifted supplied power to drywell pneumatic supply valve (AO-3-4722). Loss of power to this valve caused it to fail closed, which resulted in the MSIV's drifting close due to loss of air. A full reactor scram was subsequently received due to "MSIV's Not Full Open". During the scram 24 of the 177 control rods went full in and "bounced" back to the 02 position instead of the full-in 00 position. Also, during the scram, the selected Standby Gas Treatment (SBGT) Train "A" failed to start as required. The "B" train did start as designed after the "A" train failed. The "A" train power supply was from "Dirty Power" or house power, thus it didn't start when called upon. The licensee has corrected the power supply problem and the reactor was made critical at 11:18 a.m. and the unit returned to service at 6:03 p.m. on November 11, 1986.

d. Unit 3 - At 9:58 a.m. on November 13, 1986, while operating at 93% power, the reactor scrammed on a high power (APRM) spike due to the closure of Main Steam Isolation Valve (MSIV-1B). Maintenance personnel were troubleshooting the auxiliary feed from Bus 36-4, which was feeding the essential service bus because of problems with the essential service bus uninterruptible power supply. The opening of this auxiliary power supply caused a momentary loss of power and a half scram on safety channel B, which was followed by a full reactor scram within a few seconds. The half scram was attributed to momentary loss of essential power causing a voltage drop to the A.C. powered solenoid valves, which in conjunction with D.C. powered solenoid valves maintain air pressure to operate the MSIV's. Circuit testing of the D.C. solenoid valve on MSIV-1B established that it had failed, thus leaving only the A.C. solenoid valve controlling air pressure. The voltage drop (caused by the throw-over of the essential power) was sufficient enough to cause the A.C. solenoid to interrupt air pressure and result in the closure of MSIV-1B. This increased reactor system pressure, causing a high-high APRM spike on all 6 channels resulting in an automatic reactor scram. The licensee replaced the failed D.C. solenoid on MSIV-1B and restarted the unit on November 15, 1986.

e. Unit 3 - On November 19, 1986, at 6:20 p.m., a GSEP - Unusual Event was declared because the Unit 2/3 Emergency Diesel Generator was out-of-service for a quarterly inspection and the "A" Low Pressure Coolant Injection (LPCI) system was declared inoperable due to Suppression Pool suction valve MO 1501-5A being declared inoperable. With these systems inoperable, the Technical Specifications required the unit to be shut down within 24 hours. At 5:47 a.m. on November 20, 1986, the GSEP - Unusual Event was terminated when the 2/3 Emergency Diesel Generator was returned to service and successfully tested. The licensee has since completed repairs to the torque limit switch operator of suction valve MO 1501-5A.

The inspector informed the licensee on November 25, 1986, that the Red Phone log book in the control room was lacking an entry - that being the call on November 20, 1986 at 5:47 a.m., by a Shift Engineer terminating the Unusual Event of November 19, 1986. The center desk log did have an entry of this call.

f. Unit 2 - On November 29, 1986, at 3:45 p.m. with the unit at 15% power, and entering a refueling outage, a GSEP Unusual Event was declared due to the containment/drywell atmosphere oxygen concentration being greater than 4% oxygen and the reactor cooling pressure above 90 psig with the reactor in the Run Mode for more than the 24 hour period permitted by Technical Specification 3.7.A.5. At 5:10 p.m. on November 29, 1986, the Unusual Event was terminated when the reactor was manually scrammed by placing the mode switch in the shutdown position.

Details of this event are still under review by the Resident Inspectors and Region III office. This is considered an unresolved item (50-249/86029-01).

No violations or deviations were identified in this area.

4. Monthly Maintenance Observation

Station maintenance activities of safety related systems and components listed below were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides and industry codes or standards and in conformance with technical specifications.

The following items were considered during this review: the limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and, fire prevention controls were implemented. Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety related equipment maintenance which may affect system performance.

The following maintenance activities were observed/reviewed:

Unit 2

2B - Low Pressure Coolant Injection (LPCI) Heat Exchanger Tube Plugging and Cleaning

Unit 2 Emergency Diesel Generator quarterly inspection

125 volt Battery Rack Replacement and Replacement of the 2 and 2A 125 Volt 100 ampere Battery Chargers with 200 ampere Chargers

Unit 3

High Pressure Coolant Injection (HPCI) Pump vibration test

Common

Unit 2/3 Emergency Diesel Generator 6 Month Inspection

No violations or deviations were identified in this area.

5. Licensee Event Reports Followup

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with technical specifications.

Unit 2

(Closed) 86022-00: Fire Main Valve Position Not Verified on Schedule Due to an Oversight by the Operations Department. Fire suppression water system inspection surveillances exceeded the 31 day (plus 25 percent) valve position verification. The valves FM 2-4101-510 and FM 3-4101-507 were verified open (normal position) on September 1, 1986, one day beyond the critical surveillance due date.

(Closed) 86022-01: Fire Main Valve Position Not Verified on Schedule Due to an Oversight by the Operations Department. A Supplemental Report was issued to correct item No. 13 Component Failures. The "Cause Code" and "Reportable to NPRDS" items were filled out incorrectly. No component failure occurred.

(Closed) 86023-00: Failure of Power Supply 2-1705-7B to the Reactor Building Ventilation Monitors Caused Automatic Initiation of the Standby Gas Treatment System. The failure of the power supply for channel "B" Reactor Building ventilation monitoring system was the result of a defective dial component within the power supply which regulates the power output from the power supply. The problem was corrected when power supply 2-1705-7B was replaced like for like and successfully tested.

Unit 3

(Closed) 86012-00: Manual Scram Due to Excessive Number of Control Rod Drive (CRD) Accumulator Alarms Caused by CRD Pump Trip. Charging water manual isolation valve for CRD M-3 stuck open causing the 3B Control Rod Drive pump to run out and trip on low suction pressure. A new stem and disc were installed in the charging water manual valve (3-305-113) on CRD M-3. The valve was then successfully tested to ensure complete sealing.

(Closed) 86012-01: Manual Scram Due to Excessive Number of Control Rod Drive (CRD) Accumulator Alarms Caused by CRD Pump Trip. Supplemental Report was issued to correct procedure number and title used for the surveillance.

(Closed) 86015-00: Failure to Perform the Unit 3 Quarterly Storage Battery Surveillance During the Required Surveillance Interval Due to Personnel Error. Missed critical surveillance due date of July 29, 1986. The required surveillance was performed on July 1, 1986 beyond the 25 percent allowable extension interval. Discovery and recognition that the missed surveillance was a Technical Specification violation occurred on September 24, 1986. Dresden Administrative Procedure (DAP) 11-2, "Surveillance Program", has been revised to have the Surveillance Coordinator submit a Surveillance Frequency Overdue List to the effected departmental leads for review and comment should any item exceed the due date.

(Closed) 86016-00: Reactor Scram on Low Condenser Vacuum Due to Circulating Water Flow Reversal Valve Failure. Main condenser flow reversal valve 3-4402D failed in mid-position causing a condenser low vacuum reactor scram. The setscrew holding the motor pinion gear in place apparently vibrated loose, which caused the pinion gear to become uncoupled from the motor drive shaft preventing the valve from fully changing position during flow reversal. The motor pinion gear was reinstalled and the setscrew tightened on valve 3-4402D. Also, all other main condenser circulating water flow reversing valve motors were inspected and the setscrews checked for tightness. In addition, all pinion gears were safety wired in place to prevent future uncouplings from the motor shaft.

(Closed) 86016-01: Reactor Scram on Low Condenser Vacuum Due to Circulating Water Flow Reversal Valve Failure. A Supplemental Report was issued to provide Component Failure information and correct a typographical error.

(Closed) 86017-00: Contractor Inadvertently Jars Main Steam Line High Flow Sensing Lines Resulting in Group I Isolation and Subsequent Reactor Scram. Review of this event is documented under Paragraph 3.a. of this report.

(Closed) 86018-00: Spurious Group V Containment Isolation. Review of this event is documented in Paragraph 3.b. of this report.

The preceding LERs have been reviewed against the criteria of 10 CFR 2, Appendix C, and the incidents described meet all of the following requirements. Thus no Notice of Violation is being issued for these items.

a. The event was identified by the licensee,
b. The event was an incident that, according to the current enforcement policy, met the criteria for Severity levels IV or V violations,
c. The event was appropriately reported,
d. The event was or will be corrected (including measures to prevent recurrence within a reasonable amount of time), and
e. The event was not a violation that could have been prevented by the licensee's corrective actions for a previous violation.

No violations or deviations were identified in this area.

6. I.E. Information Notice Followup

Each of the following I.E. Information Notices (IEN) was reviewed by the Resident Inspector to verify (1) that the information notice was received by licensee management, (2) that a review for applicability was performed, and (3) that if the information notice was applicable to the facility, applicable actions were taken or were scheduled to be taken.

(Closed) IEN 86-67: Portable Moisture/Density Gauges: Recent Incidents and Common Violations of Requirement for Use, Transportation and Storage. Not applicable to Dresden.

(Closed) IEN 86-84: Rupture of a Nominal 40 Millicurie Iodine-125 Brachytherapy Seed Causing Significant Spread of Radioactive Contamination. Not applicable to Dresden.

(Closed) IEN 86-85: Enforcement Actions Against Medical Licensees for Willful Failure to Report Misadministrations. Not applicable to Dresden.

(Closed) IEN 86-86: Clarification of Requirements for Fabrication and Export of Certain Previously Approved Type B Packages. Not applicable to Dresden.

(Closed) IEN 86-92: Pressurizer Safety Valve Reliability. Not applicable to Dresden.

No violations or deviations were identified in this area.

7. IE Bulletin Followup

The following IE Bulletin was reviewed by the Resident Inspectors to determine if: (1) the licensee's written response was submitted within the time limitations stated in the bulletin, (2) the written response

included all information required to be reported, (3) the written response included adequate corrective action commitments based on information presented in the bulletin and the licensee's response, (4) licensee management forwarded copies of the written response to the required onsite management representatives, (5) information discussed in the licensee's response was accurate, and (6) the corrective action taken was as described in the response.

(Closed) I.E. Bulletin 86-03, Revision 0 (237/86003-BB; 249/86003-BB): "Potential Failure of Multiple ECCS Pumps Due to Single Failure of Air-Operated Valve in Minimum Flow Recirculation Line." The licensee's written response dated November 14, 1986, states that the single-failure problem does not exist at any of their stations. Actions required of BWR plants in response to I.E. Bulletin 86-01 were not repeated, as directed, in response to this I.E. Bulletin.

No violations or deviations were identified in this area.

8. Management Meeting at Dresden

On November 19, 1986, a meeting was held at the Dresden site to discuss recent management changes within the licensee's site organization and also within the NRCs Region III and Nuclear Reactor Regulation Licensing staff. In addition, a site tour was conducted by all NRC attendees to examine on site housekeeping activities

9. Report Review

During the inspection period, the inspectors reviewed the licensee's Monthly Operating Report for September and October, 1986. The inspectors confirmed that the information provided met the requirements of Technical Specification 6.6.A.3 and Regulatory Guide 1.16.

The licensee announced the following Dresden site management changes effective November 24, 1986:

J. Kotowski, Assistant Superintendent Work Planning transferred to Assistant Superintendent Operations.

T. Ciesla, Assistant Superintendent Operations transferred to Assistant Superintendent Work Planning.

10. Exit Interview

The inspectors met with licensee representatives (denoted in Paragraph 1) informally throughout the inspection period and at the conclusion of the inspection on December 2, 1986, and summarized the scope and findings of the inspection activities.

The inspectors also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee did not identify any such documents/processes as proprietary. The licensee acknowledged the findings of the inspection.

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