Commonwealth Edison
Dresden Nuclear Power Station
R.R. #1
Morris, Illinois 60450
Telephone 815/942-2920

June 2, 1978

BBS Ltr. #78-907

James G. Keppler, Regional Director
Directorate of Regulatory Operations - Region III
U.S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Reportable Occurrence Report #78-023/01T-0, Docket #050-249 is hereby submitted to your office in accordance with Dresden Nuclear Power Station Technical Specification 6.6.B.1.(b), operation of the unit or affected systems when any parameter or operation subject to a limiting condition is less conservative than the least conservative aspect of the limiting condition for operation established in the technical specifications.

Arthur M Roberts
for B. B. Stephenson
Station Superintendent
Dresden Nuclear Power Station

BBS/deb

Enclosure

cc: Director of Inspection & Enforcement
Director of Management Information & Program Control
File/NRC

A002
S,11

NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Field	Value
01 Licensee Code (2)	I L D R 5 3
License Number (3)	0 0 - 0 0 0 0 0 - 0 0
License Type (4)	4 1 1 1 1
CAT (5)	
CON'T 01 Report Source (6)	L
Docket Number (7)	0 5 0 0 0 2 4 9
Event Date (8)	0 5 2 0 7 8
Report Date (9)	0 6 0 2 7 8

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During startup operability surv. testing with Unit 3 in refuel mode on 5/20/78,
03 SRM's #24 and #21 were declared inoperable. Technical Specification 3.2.C.2, Table 3.2.3
04 allows only one SRM to be inoperable while in the startup condition. Safety significance
05 minimal because the deficiencies were detected before control rod drive withdrawal
06 was initiated. No previous reportable events of this type have occurred.
07
08

09	Value
System Code (11)	I A
Cause Code (12)	E
Cause Subcode (13)	B
Component Code (14)	X X X X X X
Comp. Subcode (15)	Z
Valve Subcode (16)	Z

(17) LER/RO Report Number: Event Year 7 8 — Sequential Report No. 0 2 3 / Occurrence Code 0 1 — Report Type T — Revision No. 0

Action Taken	Future Action	Effect on Plant	Shutdown Method	Hours (22)	Attachment Submitted	NPRD-4 Form Sub.	Prime Comp. Supplier	Component Manufacturer
A (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	N (25)	G 0 8 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Failure of SRM 24 to insert to its proper startup position was attributed to a
11 faulty drive cable. The cable was replaced and the SRM was successfully inserted.
12 Cause of failure of SRM 21 was due to a bad signal cable. The signal cable was
13 replaced. No further corrective actions deemed necessary at this time.
14

15 Facility Status (28)	% Power (29)	Other Status (30)	Method of Discovery (31)	Discovery Description (32)
C	0 0 0	NA	B	Surveillance tests

16 Activity Released (33)	Content of Release (34)	Amount of Activity (35)	Location of Release (36)
Z	Z	NA	NA

17 Personnel Exposures Number (37)	Type (38)	Description (39)
0 0 0	Z	NA

18 Personnel Injuries Number (40)	Description (41)
0 0 0	NA

19 Loss of or Damage to Facility Type (42)	Description (43)
Z	NA

20 Publicity Issued (44)	Description (45)	NRC Use Only
N	NA	

NAME OF PREPARER Terry Jansen PHONE: 265

ATTACHMENT TO LICENSEE EVENT REPORT 78-023/01T-0
COMMONWEALTH EDISON COMPANY (CWE)
DRESDEN UNIT-3 (ILDRS-3)
DOCKET #050-249

During startup operability surveillance testing while the Unit 3 reactor was in the refuel mode on May 20, 1978, it was found that source range monitor (SRM) 24 couldn't be driven to its proper startup position in the core. It was therefore declared inoperable. SRM 21 had previously been declared inoperable because it was reading below the Technical Specification limit of 3 counts per second. This resulted in a violation of the Technical Specification 3.2.C.2., Table 3.2.3 in which only one SRM is allowed to be inoperable in the startup condition. No previous reportable events of this type have occurred. No adverse effects on public health or safety resulted as a consequence of this event since the problems were detected before control rod drive withdrawal was initiated.

The cause of the failure of SRM 24 to insert to its proper position in the core was a faulty drive cable. The cable was replaced, and the SRM was successfully inserted. No future corrective action is necessary. The cause of the failure of SRM 21 was due to a bad signal cable. The signal cable was replaced with no future corrective actions planned.