



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

*W. Lander*

August 26, 1977

BBS Ltr. #77-781



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

**Regulatory**

**File Cy.**

Enclosed please find Reportable Occurrence Report #50-237/1977-28. This report is being submitted to your office in accordance with the Dresden Nuclear Power Station Technical Specifications, Section 6.6.B.

*B. R. Shelton for 8/26*  
B.B. Stephenson  
Station Superintendent  
Dresden Nuclear Power Station

BBS:dlz

Enclosure

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

AUG 30 1977

772500118

# LICENSEE EVENT REPORT

CONTROL BLOCK: 

--	--	--	--	--	--

(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME: 

0	1	L	D	R	S	2
---	---	---	---	---	---	---

 LICENSE NUMBER: 

0	0	-	0	0	0	0	0	-	0	0
---	---	---	---	---	---	---	---	---	---	---

 LICENSE TYPE: 

4	1	1	1	1
---	---	---	---	---

 EVENT TYPE: 

0	3
---	---

CON'T: 

0	1
---	---

 CATEGORY: 

--	--

 REPORT TYPE: 

L
---

 REPORT SOURCE: 

L
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 DOCKET NUMBER: 

0	5	0	-	0	2	3	7
---	---	---	---	---	---	---	---

 EVENT DATE: 

0	7	2	8	7	7
---	---	---	---	---	---

 REPORT DATE: 

0	8	2	6	7	7
---	---	---	---	---	---

### EVENT DESCRIPTION

0	2
---	---

 During routine operator plant inspection at 1830 hours on July 28, 1977 the water  

0	3
---	---

 tight buckhead door which provides flood protection to the containment cooling service  

0	4
---	---

 water (CCSW) vault was found open. During the previous shift, a water hose was run  

0	5
---	---

 through the water tight door to allow flushing of the condenser sodium hypochlorite  

0	6
---	---

 injection lines. The hose was immediately removed and the door closed. The door had

(OVER)

SYSTEM CODE: 

S	B
---	---

 CAUSE CODE: 

A
---

 COMPONENT CODE: 

Z	Z	Z	Z	Z	Z
---	---	---	---	---	---

 PRIME COMPONENT SUPPLIER: 

Z
---

 COMPONENT MANUFACTURER: 

Z	9	9	9
---	---	---	---

 VIOLATION: 

N
---

### CAUSE DESCRIPTION

0	8
---	---

 The event was caused by personnel error. The maintenance personnel who flushed the  

0	9
---	---

 sodium hypochlorite lines were unaware that the door was required to be closed when  

1	0
---	---

 left unattended. To ensure personnel will be aware of this requirement, permanent

(OVER)

FACILITY STATUS: 

E
---

 % POWER: 

0	6	5
---	---	---

 OTHER STATUS: 

NA
----

 METHOD OF DISCOVERY: 

B
---

 DISCOVERY DESCRIPTION: 

During Routine Operator Inspection
------------------------------------

FORM OF ACTIVITY RELEASED: 

Z
---

 CONTENT OF RELEASE: 

Z
---

 AMOUNT OF ACTIVITY: 

NA
----

 LOCATION OF RELEASE: 

NA
----

### PERSONNEL EXPOSURES

NUMBER: 

0	0	0
---	---	---

 TYPE: 

Z
---

 DESCRIPTION: 

NA
----

### PERSONNEL INJURIES

NUMBER: 

0	0	0
---	---	---

 DESCRIPTION: 

NA
----

### OFFSITE CONSEQUENCES

1	5
---	---

NA
----

### LOSS OR DAMAGE TO FACILITY

TYPE: 

Z
---

 DESCRIPTION: 

NA
----

### PUBLICITY

1	7
---	---

NA
----

### ADDITIONAL FACTORS

1	8
---	---

NA
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1	9
---	---

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NAME: Pietryga PHONE: 265

EVENT DESCRIPTION (continued)

been left open for approximately four (4) hours. The safety implications of the event were minimized since the water tight bulkhead door leading to the condensate pit was closed and the redundant level switches in the condenser pit were operable. In addition, the condensate pump room high level alarm switch was operable and would have alerted the control room operator to a flooding condition. This event is not a repetitive occurrence (50-237/1977-28).

CAUSE DESCRIPTION (continued)

signs will be posted at the bulkhead doors on both units 2 and 3. The signs are currently on order and are expected to be posted by January, 1978.

1977 SEP 6 PM 1 50

RECEIVED DOCUMENT  
PROCESSING UNIT