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BBS Ltr. #77-176 March 7, 1977

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

REFERENCES: Docket Number 50-237
Docket Number 50-249

Enclosed please find an update report to Reportable Occurrence report number 50-237/1976-63. This report is being submitted to your office in accordance with the Dresden Nuclear Power Station Technical Specifications, Section 6.6.B.

B. B. Stephenson
Station Superintendent
Dresden Nuclear Power Station

BBS:jo

Enclosure

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

MAR 15 1977

CONTROL BLOCK: [| | | | |] (1–6)

UPDATE REPORT–PREVIOUS REPORT DATE: 11-1-76

(PLEASE PRINT ALL REQUIRED INFORMATION)

	LICENSEE NAME	LICENSE NUMBER	LICENSE TYPE	EVENT TYPE
01	I L D R S 2	0 0 – 0 0 0 0 0 – 0 0	4 1 1 1 1	0 3
7 8	9–14	15–25	26–30	31–32

	CATEGORY	REPORT TYPE	REPORT SOURCE	DOCKET NUMBER	EVENT DATE	REPORT DATE
01 CON'T		L	L	0 5 0 – 0 2 3 7	1 0 0 3 7 6	0 3 0 3 7 7
7 8	57–58	59	60	61–68	69–74	75–80

EVENT DESCRIPTION

02 During normal operation, radiation protection personnel reported that stack gas

03 sample pump flow appeared to be abnormally low. An operator confirmed that 2/3

04 "A" pump flow was 2.6 SCFM; 2/3 "B" pump flow was 0.0 SCFM (flow greater than

05 2.9 SCFM is considered normal). Tech Spec section 3.8.A.1 requires continuous

06 chimney monitoring, but states that during plateout tests, when both pumps must

(Continued)

	SYSTEM CODE	CAUSE CODE	COMPONENT CODE	PRIME COMPONENT SUPPLIER	COMPONENT MANUFACTURER	VIOLATION
07	B B	A	Z Z Z Z Z Z	Z	Z 9 9 9	Y
7 8	9–10	11	12–17	43	44–47	48

CAUSE DESCRIPTION

08 Normal wear products from the carbon impeller vanes collected in the sample

09 lines, pump cavity, and filter of the 2/3 "A" pump, resulting in reduced pump

10 efficiency and flow. The zero-flow condition on the 2/3 "B" pump was caused

(Continued)

	FACILITY STATUS	% POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION
11	E	0 9 7	NA	A	NA
7 8	9	10–12	13–44	45	46–80

	FORM OF ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY	LOCATION OF RELEASE
12	Z	Z	NA	NA
7 8	9	10	11–44	45–80

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION
13	0 0 0	Z	NA
7 8	9–11	12	13–80

PERSONNEL INJURIES

	NUMBER	DESCRIPTION
14	0 0 0	NA
7 8	9–11	12–80

OFFSITE CONSEQUENCES

15 NA

LOSS OR DAMAGE TO FACILITY

	TYPE	DESCRIPTION
16	Z	NA
7 8	9	10–80

PUBLICITY

17 NA

ADDITIONAL FACTORS

18 NA

19

NAME: Randolph C. Weidner PHONE: Ext. 265

GPO 881-667

EVENT DESCRIPTION (Continued)

be out of service, the steam jet air ejector monitors may be used to satisfy the plant chimney monitoring requirements if the reactor is operating at a steady-state power level. Although a plateout test was not being performed when both pumps were forced out of service, the reactor had been operating in the steady-state condition for 13 hours, and both steam jet air ejector monitors were operable. During the period from 1725 to 1930 hours, while the 2/3 "A" sample pump and suction filter were being replaced to provide rapid compliance with Tech Spec requirements, the steady-state operation of the unit and the static response of the SJAE monitors ensured that no unacceptable releases occurred. Because the cause of failure could not be readily identified on the 2/3 "B" sample pump, it was decided to first restore the operability of the "A" sample pump by simply replacing the pump and suction filter. Personnel errors resulting in stack gas sample pump problems have occurred occasionally in the past. (50-237/1976-63)

CAUSE DESCRIPTION (Continued)

by an improper valve lineup.

As stated above, the 2/3 "A" sample pump and suction filter were replaced. The 2/3 "B" sample pump was returned to service at 1125 hours on 10/4/76, after the valving error was discovered.

Reevaluation of the events related to the temporary loss of stack gas sampling capability on October 3, 1976, has resulted in the following conclusions:

1. The proximate cause of the event was personnel error (cause code A). This conclusion is based on the fact that, at the time of the event, the operator was unable to establish flow in the standby sample train even though no equipment malfunction existed.

2. The root cause of the event was the inadequacy of the system description in the applicable operating procedure -- DOP 1700-4. Had a piping and valve diagram been included in the procedure, the operator would certainly have been able to readily perform the valving required to place the standby sample train in service.

To avoid recurrence, procedure DOP 1700-4, Off-Gas Vent (Stack) Radiation Monitoring System, was revised, and a valve and piping diagram and isometric drawing were added. Additionally, a copy of the new valve and piping diagram has been posted in the sample pump area.