



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

D. L. Latham

BBS Ltr. #76-599

August 9, 1976

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



Enclosed please find Reportable Occurrence report number 50-237/1976-49.
This report is being submitted to your office in accordance with the Dresden
Nuclear Power Station Technical Specifications, Section 6.6.B.

for *Arthur M. Roberts*
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

8298

AUG 12 1976

LICENSEE EVENT REPORT

CONTROL BLOCK:

(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	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	0	7	1	1	7	6	0	8	0	9	7	6
7	8	57	58	59	60	61							68	69					74	75			80		

EVENT DESCRIPTION

02	DURING CORE SPRAY SYSTEM VALVE OPERABILITY TESTING (REQUIRED FOR REMOVING																							80
03	THE UNIT 2/3 DIESEL GENERATOR FROM SERVICE), CORE SPRAY OUTBOARD INJECTION VALVE																							80
04	MO 2-1402-24B LOST OPEN/CLOSED INDICATION AND COULD NOT BE ELECTRICALLY REOPENED.																							80
05	THE REDUNDANT CORE SPRAY LOOP WAS OPERABLE, AS WERE BOTH LPCI SUBSYSTEMS. SIM-																							80
06	ILAR FAILURES HAVE OCCURRED TWICE IN THE PAST: ON 2/5/71 (MO 2-1402-24B), AND																							80
	(SEE ATTACHED SHEET)																							80

SYSTEM CODE		CAUSE CODE		COMPONENT CODE				PRIME COMPONENT SUPPLIER		COMPONENT MANUFACTURER				VIOLATION	
07	S	F	E	V	A	L	V	O	P	N	P	I	9	5	N
7	8	9	10	11	12				17	43	44			47	48

CAUSE DESCRIPTION

08	THE VALVE FAILURE WAS CAUSED BY A BROKEN LIMIT SWITCH CONTACT BLOCK IN																							80
09	THE VALVE OPERATOR. THE PLASTIC BLOCK, WHICH HAD BEEN TESTED BY THE MANUFAC-																							80
10	TURER WITH A FORCE OF UP TO 8 G'S IN ALL DIRECTIONS, APPARENTLY SUSTAINED SOME																							80
	(SEE ATTACHED SHEET)																							80

FACILITY STATUS		% POWER		OTHER STATUS				METHOD OF DISCOVERY		DISCOVERY DESCRIPTION			
11	E	0	9	5	NA				B	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												
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																							80
7	8	9																					80	

LOSS OR DAMAGE TO FACILITY

TYPE		DESCRIPTION												
16	Z	NA												
7	8	9	10											80

PUBLICITY

17	NA																							80
7	8	9																					80	

ADDITIONAL FACTORS

18	NA																							80
7	8	9																					80	

19																								80
7	8	9																					80	

NAME: J. KOLANOWSKI

PHONE: EXT. 265

EVENT DESCRIPTION (Continued)

on 11/27/74 (MO 3-1402-24A).
(50-237/1976-49)

CAUSE DESCRIPTION (Continued)

damage from water hammer in the core spray system. Before installation of the ECCS jockey pump charging system, inadequate system venting caused several water hammer incidents to occur on both Units 2 and 3 during normal core spray system surveillance tests. During these incidents, it is conjectured, the valve limit switch block was jarred to the point of cracking, and eventually failed after many subsequent valve cycles. Since May, 1971, surveillance procedures which require system venting prior to testing have been used in conjunction with the ECCS charging system to prevent a recurrence of water hammer conditions. No further action is considered necessary.

The failed limit switch block was replaced, and valve MO 2-1402-24B was cycled normally several times before being returned to service. Valve 1402-24B is a 10-inch Crane model 783U gate valve; the valve operator is a limitorque model SMB-1, manufactured by Philadelphia Gear Co.