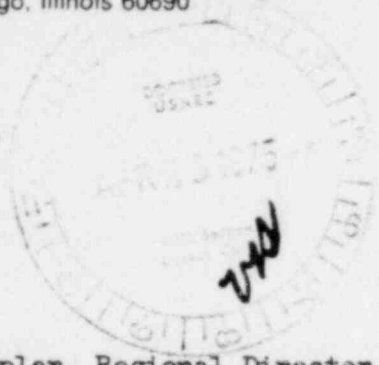




Commonwealth Edison
One First National Plaza, Chicago, Illinois
Address Reply to: Post Office Box 767
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EBS Ltr. #259-75



Dresden Nuclear Power Station
R. R. #1
Morris, Illinois 60450
April 21, 1975

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

SUBJECT: REPORT OF ABNORMAL OCCURRENCE PER SECTION 6.6.A OF THE TECHNICAL SPECIFICATIONS
CORE SPRAY VENT LINE LEAK

- References: 1) Regulatory Guide 1.16 Rev. 1 Appendix A
2) Notification of Region III of U. S. Nuclear Regulatory Commission
Telephone: P. Johnson, April 14, 1975 at 1045 hours
Telegram: J. Keppler, April 14, 1975 at 1325 hours

Report Number: 50-10/1975-6

Report Date: April 18, 1975

Occurrence Date: April 12, 1975

Facility: Dresden Nuclear Power Station, Morris, Illinois

IDENTIFICATION OF OCCURRENCE

This occurrence constitutes an abnormal degradation of a boundary designed to contain radioactive materials, in which the three quarter (3/4) inch core spray system vent line to the poison system primary steam header developed a pin-hole leak in a socket weld at a pipe-to-coupling joint.

CONDITIONS PRIOR TO OCCURRENCE

Prior to the occurrence the unit was in the RUN mode at a thermal power of 50 MWt, preparing to roll the main turbine. The sphere was in an airborne condition.

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April 21, 1975

DESCRIPTION OF OCCURRENCE

At 0030 on April 12, the Unit 1 sphere was placed on an airborne status, with full face mask requirements. At approximately 0730 a sphere inspection was begun to determine the source of the airborne condition. At 0930 the leak in the core spray system vent line was discovered and immediately isolated. At 1445 on April 15, the sphere was removed from the airborne status.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE (Equipment Failure)

The cause of the occurrence was failure of the pipe-to-coupling socket weld, resulting in a pinhole leak. The cause of the failure was determined to be a slag inclusion in the weld and poor adhesion of the weld material.

ANALYSIS OF OCCURRENCE

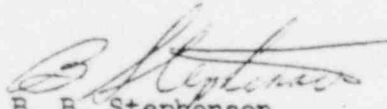
The health and safety of the public and plant personnel were not endangered as a result of this occurrence. All leakage resulting from this occurrence was contained within the primary containment boundary, monitored, and released only through the facility radwaste system or ventilation stack. During the occurrence no release limits were exceeded. Additionally, the sphere air was continuously monitored for airborne radioactivity concentrations and respiratory protective equipment was prescribed in a timely manner for personnel protection.

CORRECTIVE ACTION

On April 17, the affected coupling and short sections of pipe on each side of the coupling were removed and replaced. Since the weld failure was strictly mechanical in nature and not related to stress or corrosion cracking, no additional corrective action is required.

FAILURE DATA

A review of Unit 1 incident reports indicate that this is the first failure of a socket weld in small diameter (< 2") piping. The failed weld was in line CS-116-3/4.


B. B. Stephenson
Superintendent

BBS:RFJ:smp

File/NRC