



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

DCD

October 22, 1991

EDE LTR #91-653

U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Licensee Event Report #83-62/01X-2, Docket #050-237 is being submitted as required by Technical Specification 6.6 and NUREG 1022. This revised report is submitted in order to provide an update concerning further investigation into this event, which concerned failure of a High Pressure Coolant Injection Motor Gear Unit signal converter operational amplifier.

E. D. Eenigenburg

E. D. Eenigenburg
Station Manager
Dresden Nuclear Power Station

EDE/dwh

Enclosure

cc: A. Bert Davis, Regional Administrator, Region III
NRC Resident Inspector's Office
File/NRC
File/Numerical

1022

ZDVR/350

9111050219 840216
PDR ADOCK 05000237
S PDR

NOV 1 1991

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[illegible]

CON'T

REPORT SOURCE: L 6 0 5 0 0 0 2 3 7 7 0 8 1 9 8 3 8 0 2 1 6 8 4 9

DOCKET NUMBER: 60 81

EVENT DATE: 66 69

REPORT DATE: 74 75

EVENT DESCRIPTION: 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
1. The aircraft was flying at a low altitude (approximately 100 feet) over the water. The aircraft was flying in a southerly direction. 2. The aircraft was flying in a southerly direction. 3. The aircraft was flying in a southerly direction. 4. The aircraft was flying in a southerly direction. 5. The aircraft was flying in a southerly direction. 6. The aircraft was flying in a southerly direction. 7. The aircraft was flying in a southerly direction. 8. The aircraft was flying in a southerly direction. 9. The aircraft was flying in a southerly direction. 10. The aircraft was flying in a southerly direction.

During normal operation, the HPCI motor gear unit (MGU) was observed to be moving between the high and low speed stops without Operator action. This event is of minimal safety significance because HPCI could still automatically initiate, and Operator action was taken to manually set flow at the high speed stop. There was no effect on public health or safety. A previous event of this type was reported on R.O. 82-27 on Docket 50-237.

SYSTEM CODE 09		CAUSE CODE S F 11		CAUSE SUBCODE E 12		COMPONENT CODE I N S T R U 14				COMP. SUBCODE C 15		VALVE SUBCODE Z 16	
LER/RO REPORT NUMBER 17		EVENT YEAR 8 3 21		SEQUENTIAL REPORT NO. 0 6 12 26		OCCURRENCE CODE 0 1 28		REPORT TYPE X 30		REVISION NO. 2 32			
ACTION TAKEN A 18		FUTURE ACTION X 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22		ATTACHMENT SUBMITTED Y 23		NPRO-4 FORM SUB. Y 24	
PRIME COMP. SUPPLIER N 25		COMPONENT MANUFACTURER T 1 0 9 26											

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 1 0 The cause was failure of a MGU signal converter operational amplifier,
1 1 1 which was replaced. Elevated ambient temperatures were originally
1 1 2 suspected to be a contributing factor; however, further investigation
1 1 3 concluded that this electronic circuit board component failure was random
1 1 4 in nature.

FACILITY STATUS (1) 5 (2) E (28) % POWER (1) 0 (2) 0 (29) OTHER STATUS (30) N/A METHOD OF DISCOVERY (31) A DISCOVERY DESCRIPTION (32) Operator Observation

ACTIVITY CONTENT
RELEASED OF RELEASE

	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
1	6		Z	(33)	Z	(34)	N/A																				
7	8	9																									

AMOUNT OF ACTIVITY (35) N/A

LOCATION OF RELEASE (36) N/A

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	000	37 Z	18 N/A					

PERSONNEL INJURIES		DESCRIPTION	
NUMBER			
0	0	0	40
		N/A	

8		9		11		12	
TYPE		DESCRIPTION					
1	9	2	42	N/A		(43)	

8 9 10

PUBLICITY

ISSUED DESCRIPTION (45)

2 0 N 44 N/A

NRC USE ONLY

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NAME OF PREPARER Mark Churilla

PHONE: (815) 942-2920 x 2788

ATTACHMENT TO LICENSEE EVENT REPORT 83-62/01X-2
COMMONWEALTH EDISON COMPANY (CWE)
DRESDEN UNIT 2 (ILDRS 2)
DOCKET # 050-237

During normal operation, an Operator observed the High Pressure Coolant Injection (HPCI) motor gear unit (MGU) moving between the high speed stop and low speed stop. The safety significance was considered minimal because HPCI could still initiate automatically, and the flow was manually controllable.

Elevated ambient temperatures were originally believed to be a contributing factor to this event. However, upon further investigation, it was concluded that this electronic circuit board component failure was random in nature. Failures of this type have not been a recurring adverse trend. Insulation improvements have been made to the HPCI piping in order to help limit heat input to the HPCI room and periodic thermography inspections have been instituted in order to monitor high/low pressure interfaces. Therefore, no further actions concerning the signal converter are required at this time.