

LICENSEE EVENT REPORT

Update Report: Previous Report

Date 9-24-81

CONTROL BLOCK: [][][][][][][][][][] [1] []

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0][1] [I][L][D][R][S] [3] [2] [0][0]-[0][0][0][0][0][0]-[0][0] [3] [4][1][1][1][1] [4] [] [5]

CON'T [0][1] REPORT SOURCE [L] [6] [0][5].[0][0][0][2][4][9] [7] [0][9][1][4][8][1] [8] [0][2][2][5][8][2] [9]

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES [10] [0][2] During normal operation while performing ADS Valve operability surveillance, the "B" [6][3] electromatic relief valve failed to open at rated pressure. Because of HPCI inoperabil- [0][4] ity, per T.S. 3.5.C., an immediate shutdown began at 2240 hrs. Minimal effect upon [0][5] public health and safety because remaining ADS valves and low pressure ECCS systems were [0][6] operable, and Reactor was at less than 90 psig within the required 24 hours. Last simi- [0][7] lar occurrence reported by R.O. 50-249/80-21. [0][8]

[0][9] SYSTEM CODE [S][F] [11] CAUSE CODE [E] [12] CAUSE SUBCODE [B] [13] COMPONENT CODE [V][A][L][V][E][X] [14] COMP. SUBCODE [X] [15] VALVE SUBCODE [B] [16]

[17] LER/RO REPORT NUMBER [8][1] EVENT YEAR [18][1] SEQUENTIAL REPORT NO. [0][2][5] OCCURRENCE CODE [0][1] REPORT TYPE [X] REVISION NO. [1] ACTION TAKEN [C] [18] FUTURE ACTION [X] [19] EFFECT ON PLANT [A] [20] SHUTDOWN METHOD [A] [21] HOURS [0][1][1][6] ATTACHMENT SUBMITTED [Y] [23] NPD-4 FORM SUB. [Y] [24] PRIME COMP. SUPPLIER [N] [25] COMPONENT MANUFACTURER [D][2][4][3] [26]

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS [27] [1][0] The apparent cause of failure was excessive leakage on the threads between the cage and [1][1] the disc retainer plug. The valve was replaced with a valve that had the threaded area [1][2] welded to prevent leakage. To prevent future recurrence, the valve threads will be seal [1][3] welded until a more acceptable alternative is found. [1][4]

[1][5] FACILITY STATUS [E] [28] % POWER [0][7][4] [29] OTHER STATUS [N/A] [30] METHOD OF DISCOVERY [C] [31] DISCOVERY DESCRIPTION [Surveillance Test] [32]

[1][6] ACTIVITY CONTENT [Z] [33] AMOUNT OF ACTIVITY [N/A] [35] LOCATION OF RELEASE [N/A] [36]

[1][7] PERSONNEL EXPOSURES NUMBER [0][0][0] [37] TYPE [Z] [38] DESCRIPTION [N/A] [39]

[1][8] PERSONNEL INJURIES NUMBER [0][0][0] [40] DESCRIPTION [N/A] [41]

[1][9] LOSS OF OR DAMAGE TO FACILITY TYPE [Z] [42] DESCRIPTION [N/A] [43]

[2][0] PUBLICITY ISSUED [N] [44] DESCRIPTION [N/A] [45] 8203310477 820225 PDR ADOCK 05000249 S PDR NRC USE ONLY

ATTACHMENT TO LICENSEE EVENT REPORT 81-25/01X-1

COMMONWEALTH EDISON COMPANY (CWE)

DRESDEN UNIT 1LDRS-3

DOCKET # 050-249

On September 14, 1981, while under normal operation and performing the rated pressure portion of the operating surveillance, DOS 250-5, (Automatic Blowdown System at Low Pressure and Rated Pressure), the 3-203-3B electromatic relief valve failed to open. There were three unsuccessful attempts made by operating personnel to open the valve.

Due to an earlier discovery of water in the HPCI steam supply line, the HPCI system was declared inoperable. As required by the Technical Specifications, Section 3.5.C., the operability surveillances were begun on the ECCS systems: ADS, Core Spray, LPCI and Isolation Condenser. Since the station was unable to meet the operational requirements of the ADS system, an orderly shutdown of the Unit 3 reactor commenced at 2240 hours. The NRC was informed, and an unusual event was declared per the Dresden Generating Station Emergency Plan. The GSEP unusual event was terminated, NRC informed, and the reactor was at less than 90 psig at 1015 hours on September 15, 1981.

There was minimal effect upon public health and safety because the remaining four ADS relief valves were operable, the low pressure ECCS systems were functional, and the reactor was at a pressure less than 90 psig within the 24 hour time limit. In addition, the HPCI system could have been made available to perform its required function if necessary by clearing the outage on the system. Previously completed surveillances indicate that the HPCI system was operational and would perform its intended function.

The apparent cause of the failure was excessive leakage on the threads between the cage and the disc retainer plug. During the course of the outage, the entire 3-203-3B electromatic relief valve was replaced with a spare valve that had the threaded area welded to prevent leakage. During startup, the operability surveillance was performed satisfactorily on 3B electromatic relief valve. To prevent future occurrences, the valve threads will be seal welded until a more acceptable alternative is found. The electromatic relief valve is a Dresser, Model Number 1525VX.

SUPPLEMENT TO DVR

DVR NO.	STA	UNIT.	YEAR	NO.
D - 12 - 3 - 81 - 52				

PART 1	TITLE OF EVENT	OCCURRED
	Failure of 3B Electromatic Relief Valve to Open	9-14-81 2223
		<u>DATE</u> <u>TIME</u>
	REASON FOR SUPPLEMENTAL REPORT	
	Up date cause of failure and corrective action	
PART 2		
	ACCEPTANCE BY STATION REVIEW	
	<i>Bruno Mitchell Wright</i>	
	DATE	
	3/9/82 3-11-82	
	SUPPLEMENTAL REPORT APPROVED AND AUTHORIZED FOR DISTRIBUTION	
	<i>Douglas Scott</i>	3/12/82
	STATION SUPERINTENDENT	DATE