

CONTROL BLOCK:

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7

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	I	L	D	R	S	2	2	0	0	-	0	0	0	0	0	0	0	3	4	1	1	1	1	4					5		
7	8	LICENSEE CODE						14		LICENSE NUMBER										26	LICENSE TYPE						32					36

CONT

0	1
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REPORT SOURCE

L	6	0	5	0	0	0	2	3	7	7	0	6	0	8	8	3	2	0	6	2	9	8	3	3
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DOCKET NUMBER

EVENT DATE

REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | During normal operations, the circuit breaker for the Core Spray Injection Valve

0 3 | M02-1402-25B was found tripped. (Tech Spec 3.5.A.1). Safety significance was

0 4 | minimal since the "A" loop was operational and capable of providing core cooling.

0 5 | No effect on public health or safety. Last previous occurrence of incorrect

0 6 | breaker settings reported by R.O. 83-18 on Docket 50-249.

0 7 |

0 8 |

SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE				COMP SUBCODE		VALVE SUBCODE				
S	F	A		C		C	K	T	B	R	K	A		Z		
9	10	11	12	12	13	13	14	15	16	17	18	19	20			
EVENT YEAR		SEQUENTIAL REPORT NO		OCCURRENCE CODE		REPORT TYPE		REVISION NO.								
8	3	—	0	4	5	—	0	3	L	—	0					
21	22	23	24	25	26	27	28	29	30	31	32					
ACTION TAKEN		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		PRIME COMP SUPPLIER		COMPONENT MANUFACTURER				
E	H	Z		Z		0	0	0	0	Y	N	N	G	0	8	0
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 Cause of the event was due to personnel error. The circuit breaker was found with
2 an incorrect setting of two (2) while a previous work request 27483 required a
3 setting of five (5). The breaker was set at (5) and the valve was cycled from
4 the control room. The significance of the event was discussed with the personnel
5 involved.

FACILITY STATUS						% POWER						OTHER STATUS						METHOD OF DISCOVERY						DISCOVERY DESCRIPTION																													
1	5	E	(28)	9	7	(29)	N/A	(30)	A	(31)	Operator Observation											(32)																															
ACTIVITY CONTENT																																																					
RELEASED OF RELEASE																		AMOUNT OF ACTIVITY																		LOCATION OF RELEASE																	
1	6	Z	(33)	Z	(34)	N/A												(35)	N/A												(36)																						
PERSONNEL EXPOSURES																																																					
NUMBER						TYPE						DESCRIPTION																																									
1	7	0	0	0	(37)	Z	(38)	N/A												(39)																																	
PERSONNEL INJURIES																																																					
NUMBER						DESCRIPTION																																															
1	8	0	0	0	(40)	N/A												(41)																																			
LOSS OF OR DAMAGE TO FACILITY																																																					
TYPE						DESCRIPTION																																															
1	9	Z	(42)	N/A												(43)																																					
PUBLICITY																																																					
ISSUED						DESCRIPTION																																															
2	0	N	(44)	N/A												(45)																																					
S																		PDR																																			
PDR ADOCK 05000237																		PDR																																			
																		NRC USE ONLY																																			

NAME OF PREPARER Lawrence M. Coyle

PHONE (815) 942-2920 x526



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

DmB

June 29, 1983

DJS Ltr #83-641

James G. Keppler, Regional Administrator
Region III
U.S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Reportable Occurrence Report #83-45/03L-0, Docket #050-237 is being submitted to your office in accordance with Dresden Nuclear Power Station Technical Specification 6.6.B.2.(b), conditions leading to operation in a degraded mode permitted by a limiting condition for operation or plant shutdown required by a limiting condition for operation.

D.J. Scott
Station Superintendent
Dresden Nuclear Power Station

DJS/kjl

Enclosure

cc: Director of Inspection & Enforcement
Director of Management Information & Program Control
U.S. NRC, Document Management Branch
File/NRC

JUL 8 1983
1/1 IE22



Commonwealth Edison

DEVIATION REPORT

DVR NO. 12 - 2 - 83 - 84
STA UNIT YEAR NO.

PART 1 TITLE OF DEVIATION

2-1402-25B Valve Breaker Found Tripped

OCCURRED

6/8/83

0615

DATE

TIME

SYSTEM AFFECTED 1400

PLANT STATUS AT TIME OF EVENT

Core Spray

MODE Run

PWR(MWT) 2460

LOAD(MWE) 804

TESTING

YES NO

DESCRIPTION OF EVENT

At 0615 the M02-1402-25B valve indication was found out. Bulb was good. A check of the breaker showed that the breaker had tripped. An earlier check of the panels at 0215 revealed no problems. The valve was successfully cycled three times and a work request was written to check breaker and valve.

 10 CFR50.72 NRC RED PHONE
NOTIFICATION MADE
☐☒

YES

NO

EQUIPMENT FAILURE D28428

☒ YES☐ NO

WORK REQUEST NO.

RESPONSIBLE SUPERVISOR J. Gates

DATE 6/8/83

PART 2 OPERATING ENGINEER'S COMMENTS

The motor and breaker for valve M02-1402-25B will be checked by Electrical Maintenance to ensure that they function properly.

☐ EVENT OF PUBLIC INTEREST☐ TECH. SPEC. VIOLATION☐ NON REPORTABLE OCCURRENCE☐ 14 DAY REPORTABLE/T.S.☒ 30 DAY REPORTABLE/T.S. 6.6.B.2.b☐ ANNUAL/SPECL REPORT REQ'D☐ 24-HOUR NRC NOTIFICATION REQ'D

TELEPH

N/A

REGION III

DATE

TIME

TELEGM/TELECOPY

N/A

REGION III

DATE

TIME

☐ CECO CORPORATE NOTIFICATION MADE
IF ABOVE NOTIFICATION IS PER 10CFR21

☐ 5-DAY WRITTEN REPORT REQ'D PER 10CFR21

A.I.R. #

L.E.R. # 83-45/03L-0

Telecopy

FACSIMILE

Dennis P. Galle

CECO CORPORATE OFFICER

6/8/83

1130

DATE

TIME

PRELIMINARY REPORT
COMPLETED AND REVIEWED

John M. Almer

OPERATING ENGINEER

6/8/83

DATE

INVESTIGATED REPORT & RESOLUTION
ACCEPTED BY STATION REVIEWRESOLUTION APPROVED AND
AUTHORIZED FOR DISTRIBUTION

STATION SUPERINTENDENT

DATE

ATTACHMENT TO LICENSEE EVENT REPORT 83-45/03L-0
COMMONWEALTH EDISON COMPANY (CWE)
DRESDEN UNIT 2 (ILDRS - 2)
DOCKET # 050-237

During normal operations, the circuit breaker for the Core Spray Injection Valve MO 2-1402-25B was found tripped. (Tech Spec 3.5.A.1). Safety significance was minimal since the "A" loop was operational and capable of providing core cooling. There was no effect on public health or safety. Previous similar occurrences were reported by: R.O. 82-27, 83-20, and 83-22 on Docket 50-237; and R.O. 83-18 on Docket 50-249.

Cause of the event was due to personnel error. The circuit breaker was found with an incorrect setting of two (2); a previous work request, 27483, required a setting of five (5). The reason for the incorrect breaker setting began with R.O. 82-87 on Docket 50-237. The occurrence involved the LPCI Heat Exchanger Bypass Valve 2-1501-11A. The breaker was found set at one (1) instead of (2). Work requests were then written to inspect the settings on a random sampling of circuit breakers of safety related valves. (WR's 25289, 25290). The circuit breaker for cleanup valve 3-1201-4 was found to be incorrectly set. Additional work requests (25476, 25477) were then written to inspect the circuit breaker settings on all the safety related motor operated valves. However, Electrical Maintenance checked the breaker settings in the plant against a data sheet which contained a listing of breaker settings which was not controlled by station procedures. The data sheet for the core spray injection valves 3(2)-1402-25 indicated a breaker trip setting of two (2) instead of the correct setting of five (5). Subsequently, the breaker settings for 3(2)-1402-25A and 25B were incorrectly set at (2). The mistake was discovered after R.O. 83-18 occurred on Docket 50-249 on May 2, 1983.

Work requests (27483, 27484, 27485, 27486) were written to reset the breaker settings from (2) to (5) for the 1402-25 A and B valves on both units and also to verify proper overload heater size because they were also incorrect on the data sheet. The breaker settings were changed from (2) to (5) and the proper overloads were verified to be installed in 2-1402-25A, 3-1402-25A and 3-1402-25B. However, incorrect overloads were found in 2-1402-25B and the job was put on hold while waiting for parts. The breaker setting should have been changed from (2) to (5) at that time but was not. Consequently, the breaker again tripped due to its low setting of (2) when the valve was cycled on June 8, 1983. The immediate corrective action taken was to reset the breaker from (2) to (5). A procedure revision was also initiated to formally incorporate the data sheet into a Dresden Maintenance Procedure to ensure proper control. The data sheet has been reviewed by management to verify all information contained is now correct. The entire event was discussed with the Electrical Maintenance management individual involved and the significance of his poor judgement in waiting for new heaters before changing the breaker setting was explained. Proper overload heaters were obtained and installed on June 18, 1983, completing the work.

DOS 1400-2, Core Spray Valve Operability Check, which cycles 2(3) 1402-25A and B is performed monthly.