

LICENSEE EVENT REPORT

CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 I L D R S 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5
7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58CONT
01 REPORT SOURCE L 6 0 5 0 0 0 2 4 9 7 0 2 0 8 8 3 8 0 2 1 8 8 3 9
7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 During normal operation with DOS 1500-1 (LPCI Valve Operability Test) in progress
03 because the 2/3 diesel generator was inoperable for a routine inspection, LP'I pump
04 suction valve, MO3-1501-5D failed to open. Safety significance was minimal since
05 the other three LPCI pumps were operable. There was no effect on public health or
06 safety. Previous occurrence reported by R.O. 82-26 on Docket #50-237.
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7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
S F 11 E 12 B 13 C K T B R K 14 B 15 Z 16
17 LER/RO REPORT NUMBER 18 EVENT YEAR 19 SEQUENTIAL REPORT NO. 20 OCCURRENCE CODE 21 REPORT TYPE 22 REVISION NO.
8 3 0 0 6 0 1 T 0
23 ACTION TAKEN 24 FUTURE ACTION 25 EFFECT ON PLANT 26 SHUTDOWN METHOD 27 HOURS 28 ATTACHMENT SUBMITTED 29 NRC-4 FORM SUB. 30 PRIME COMP. SUPPLIER 31 COMPONENT MANUFACTURER
A 18 Z 19 Z 20 0 0 0 0 Y 23 Y 24 N 25 G 0 8 0 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 Cause of the event was due to an auxiliary contact (CR 105X) in the control cir-
11 cuitry of the valve. The exact type of the contact failure could not be determined
12 because the contact functioned properly upon removal and testing. The valve was put
13 in the open position so that its ECCS function would be retained. The contact was
14 subsequently replaced and the valve cycled from control room to verify operability.
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10015 FACILITY STATUS 16 POWER 17 OTHER STATUS 18 METHOD OF DISCOVERY 19 DISCOVERY DESCRIPTION 20
E 28 0 9 9 29 N/A B 31 Surveillance Test
7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
ACTIVITY CONTENT 21 RELEASED OF RELEASE 22 AMOUNT OF ACTIVITY 23 LOCATION OF RELEASE 24
Z 33 Z 34 N/A N/A
7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
PERSONNEL EXPOSURES 25 NUMBER 26 TYPE 27 DESCRIPTION 28
0 0 0 37 Z 38 N/A
7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
PERSONNEL INJURIES 29 NUMBER 30 DESCRIPTION 31
0 0 0 40 N/A
7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
LOSS OF OR DAMAGE TO FACILITY 32 TYPE 33 DESCRIPTION 34
Z 42 N/A
7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
PUBLICITY 35 ISSUED DESCRIPTION 36
N 44 N/A
7 8 9 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 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 1008302280524 830218
PDR ADOCK 05000249
S PDR

NRC USE ONLY

NAME OF PREPARER

Lawrence Coyle

PHONE:

815-942-2920, X-526

ATTACHMENT TO LICENSEE EVENT REPORT #83-06/01T-0

COMMONWEALTH EDISON COMPANY (CWE)

DRESDEN UNIT 3 (ILDRS 3)

DOCKET #050-249

During normal operation, while DOS 1500-1 (LPCI Valve Operability) was in progress as required because the unit 2/3 diesel generator was inoperable for a scheduled inspection, LPCI pump suction valve M03-1501-5D failed in the closed position and a GSEP "Unusual Event" was declared. Safety significance was considered minimal since the remaining three LPCI pumps were operable and capable of providing the required flow. A similar occurrence was reported by R.O. 82-26 on Docket #50-237.

Cause of the event was due to an auxiliary contact (CR 105X) in the control circuitry of the valve. The exact type of contact failure could not be determined because the contact functioned properly when it was removed and tested. The valve was put in the open position so that its ECCS function would be retained. The contact was replaced and the valve was cycled successfully from the control room. DOS 1500-1 will continue to be performed monthly.