



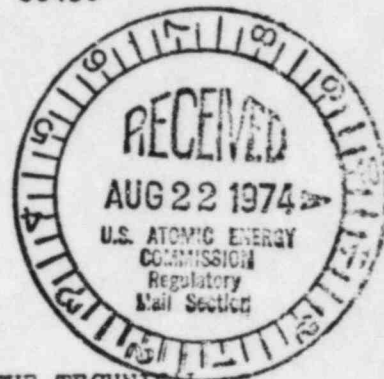
Commonwealth Edison  
One First National Plaza, Chicago, Illinois  
Address Reply to: Post Office Box 767  
Chicago, Illinois 60690

BBS Ltr.#595-74

Dresden Nuclear Power Station  
R. R. #1  
Morris, Illinois 60450  
August 16, 1974

50 - 237

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



SUBJECT: REPORT OF ABNORMAL OCCURRENCE PER SECTION 6.6.B OF THE TECHNICAL SPECIFICATIONS.  
WEEKLY TURBINE CONTROL VALVE SURVEILLANCE.

References: 1) Regulatory Guide 1.16 Rev.1 Appendix A

2) Notification of Region III of AEC Regulatory Operations  
Telephone: Mr. F. Maura, 1340 hours on August 12, 1974  
Telegram: Mr. J. Keppler, 1350 hours on August 12, 1974

3) Drawing Number: P&ID M-12

Report Number: 50-237/1974-39

Report Date: August 16, 1974

Occurrence Date: August 10, 1974

Facility: Dresden Nuclear Power Station, Morris, Illinois

#### IDENTIFICATION OF OCCURRENCE

At 2220 hours on August 10, 1974, #1 control valve failed to give a  $\frac{1}{2}$  scram during surveillance testing. The valve operated satisfactorily.

#### CONDITIONS PRIOR TO OCCURRENCE

At 2220 hours on August 10, 1974, Unit 2 was in the run mode producing 1758 MWt and 549 MWe.

#### DESCRIPTION OF OCCURRENCE

At 2220 hours on August 10, 1974, weekly turbine control valve surveillance was being conducted on Unit 2. #1 control valve fast acting solenoid failed to give a  $\frac{1}{2}$  scram signal. The load drop was continued to

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August 16, 1974

below the point where the scram is required. An electrician inspected the switch and found no obvious problem. The control valve was then tested again and the switch operated satisfactorily.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE (Other)

No apparent cause could be found.

ANALYSIS OF OCCURRENCE

There were no safety consequences to the public or plant personnel as a result of this occurrence because the remainder of the trip logic was operating correctly and the unit would have scrambled on a generator trip.

CORRECTIVE ACTION

The immediate corrective action was to reduce power below 40%; inspect the switch, relays, and connecting wires; and functionally test the system two more times. The system operated satisfactorily each time, so no further immediate corrective action was deemed necessary.

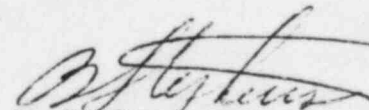
This system is tested weekly and is being monitored for similar problems.

FAILURE DATA

Review of station records has found no failures of this type in this or similar systems.

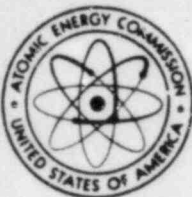
Since the cause of the malfunction could not be determined, no component data can be given.

Sincerely,



B. B. Stephenson  
Superintendent

BBS:LJD:do



UNITED STATES  
ATOMIC ENERGY COMMISSION  
DIRECTORATE OF REGULATORY OPERATIONS  
REGION III  
799 ROOSEVELT ROAD  
GLEN ELLYN, ILLINOIS 60137

TELEPHONE  
(312) 858-2660

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C. Incident Notification From: Commonwealth Edison Co., Docket No. 50-237  
(Licensee & Docket No. (or License No.))

Transmittal Date : October 23, 1974

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