



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

BBS Ltr. #332-75

Dresden Nuclear Power Station  
R. R. #1  
Morris, Illinois 60450  
May 30, 1975

JUN 3

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

SUBJECT: REPORT OF ABNORMAL OCCURRENCE PER SECTION 6.6.A OF THE TECHNICAL  
SPECIFICATIONS  
MAIN STEAM LINE HI-TEMP SWITCH SETPOINT DRIFT

- References: 1) Regulatory Guide 1.16 Rev. 1 Appendix A
- 2) Notification of Region III of U. S. Nuclear Regulatory Commission  
Telephone: P. Johnson, 1400 hours on May 23, 1975  
Telegram: J. Keppler, 1450 hours on May 23, 1975
- 3) Drawing Number 12E2501

Report Number: 50-249/1975-28

Report Date: May 30, 1975

Occurrence Date: May 22, 1975

Facility: Dresden Nuclear Power Station, Morris, Illinois 60450

#### IDENTIFICATION OF OCCURRENCE

Main Steam Line (MSL) Area Temperature Sensors 261-16B, 261-17 A-D, and 261-18D were found with setpoints above the 200°F technical specification limit.

#### CONDITION PRIOR TO OCCURRENCE

Unit-3 was in the shutdown mode in a refueling outage.

#### DESCRIPTION OF OCCURRENCE

On May 22, 1975, during the routine scheduled calibration of the MSL area temperature sensors, the setpoints were found to be above the 200°F limit. The reactor was shutdown with the head removed.

9306130045 750530  
PDR ADDOCK 05000249  
S PDR

6045-A

May 30, 1975

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE (Design Error)

The existing temperature sensors are not suited for a "first operation" surveillance type operation.

ANALYSIS OF OCCURRENCE

The function of the temperature sensors is to isolate the main steam lines in the event of a steam leak in the outboard Main Steam Line Isolation valve area. The "as-found" setpoint of the 16 switches involved would have provided an isolation at 184°F (within the tech specs limit). It is therefore concluded that the safety of the plant personnel and the general public was not jeopardized as a result of this occurrence.

CORRECTIVE ACTION

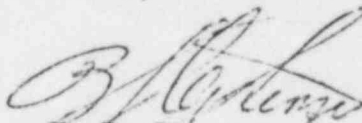
Immediate corrective action was to reset the switches to within the technical specification limit.

To prevent a recurrence of this nature, a plant modification (M-12-3-74-175) will be made after the liquid filled temperature sensors installed in the HPCI area have been satisfactorily operated. Present data indicates that the liquid filled temperature sensor can be more accurately calibrated, assuring a consistent setpoint.

FAILURE DATA

Many setpoint violations have been discovered on Fenwal temperature sensors on both units 2 & 3. Subsequent investigation has determined that the existing switches are misapplied; an accurate "first operation trip set point" cannot be consistently obtained. The manufacturer of the switches (Fenwal, Inc.) has investigated the problem and has stated that existing switches are not properly suited for a "first operation trip setpoint".

The switches involved are Fenwal Series 17000 hermetically sealed thermo switch type units.

  
B. B. Stephenson  
Superintendent

BBS:smp

File/NRC