



Commonwealth Edison  
1400 Opus Place  
Downers Grove, Illinois 60515

April 10, 1992

U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

Attention: Document Control Desk

Subject: Dresden Nuclear Power Station Units 2 and 3  
Response to Notice of Violation  
Inspection Report 50-237/92002; 50-249/92002  
NRC Docket Numbers 50-237 and 50-249

References: (a) E. Greenman letter to C. Reed dated  
March 12, 1992, transmitting NRC Inspection Report  
50-237/92002; 50-249/92002

Enclosed is Commonwealth Edison Company's (CECo) response to the Notice of Violation (NOV) which was transmitted with the reference letter and Inspection Report. The NOV cited two Severity Level IV violations each requiring a written response. Violation 237/92002-02 concerns the adequacy of corrective actions. Violation 237/92002-03 concerns maintenance of the minimum number of operable intermediate range monitors in each reactor protection trip channel while in refuel. Our response to the specific violations is provided in the attachment.

Dresden Station recognizes that these events are of concern relative to the effectiveness of past corrective actions. Accordingly, Station Management has arranged for the Corporate Safety Assessment Department to assess if additional actions are needed to ensure that corrective actions at Dresden Station effectively preclude recurrence of events. If additional actions are deemed advisable they will be incorporated in a station action plan. A supplement to this response will be provided by June 15, 1992, detailing the action plan and any other actions taken.

If your staff has any questions or comments concerning this letter, please refer them to Denise Saccomando, Compliance Engineer at (708) 515-7285.

Very truly yours,

T.J. Kovach  
Nuclear Licensing Manager

Attachment

cc: A. B. Davis, Regional Administrator-Region III  
B. L. Siegel, Project Manager, NRR  
W. G. Rogers, Senior Resident Inspector, Dresden

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ATTACHMENT  
RESPONSE TO NOTICE OF VIOLATION

NRC INSPECTION REPORT

50-237/92002; 50-249/92002

VIOLATION: (237/92002-02)

10 CFR 50 Appendix B, Criterion XVI, "Corrective Actions," states in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above:

- a. Corrective actions to a condition adverse to quality occurring on July 8, 1991, a non-qualified instrument maintenance mechanic performing a surveillance without direct supervision from the foreman, failed to preclude repetition of a non-qualified instrument mechanic performing a surveillance without direct supervision on February 4, 1992.
- b. Corrective actions to a condition adverse to quality occurring on December 8, 1990, an unplanned Unit 2 Group II isolation, failed to preclude repetition of an unplanned Unit 3 Group II isolation on January 15, 1992, due to the same cause.

REASON FOR VIOLATION - Example a

An Instrument Maintenance Supervisor assigned an instrument mechanic (IM) to perform a job before determining that the mechanic had not been trained. The supervisor became preoccupied with other job responsibilities and failed to follow the Job Assignment Matrix. Consequently, the documentation required for the assignment of non-qualified mechanics to specific jobs also was not completed.

#### CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED - Example a

Upon identification that the IM was not qualified to perform the job, the job was stopped. The difficult steps in the procedure were clarified by the supervisor with the IM and the qualified IM. The work that had been performed was reviewed with no deficiencies identified. The IM then continued working on the job under the direct supervision of the supervisor.

The use of the Job Assignment Matrix and documentation form IMD Memo #8 was discussed with all Instrument Maintenance Supervisors with strict adherence emphasized. Additionally, the supervisor was counseled on his performance and management expectations.

Subsequent to the event, the Instrument Maintenance Department has performed periodic audits of the work assignment sheets to ensure compliance with the Job Assignment Matrix. No discrepancies have been identified.

#### CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATION - Example a

A Job Assignment Matrix check off block was added to the supervisor daily turn-over sheet. This will ensure that the supervisor reviews the Job Assignment Matrix before assigning jobs to the IMs.

#### DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED - Example a

Full compliance was achieved with the revision to Maintenance Supervisors Turnover Sheet.

#### REASON FOR VIOLATION - Example b

An electrician inadvertently disrupted the neutral ground circuit for the containment isolation valves while performing a surveillance, causing an unplanned partial Primary Containment Group II isolation on Unit 3. This event was similar to a Unit 2 partial Group II isolation. The corrective actions for the Unit 2 event included a review of the wiring configuration for the system involved and a field verification of the procedures for both units. However, due to personnel error, the field verification of the procedure failed to identify/correct the discrepancy on Unit 3 which resulted in the event described in the violation.

**CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED - Example b**

Dresden Electrical Surveillance (DES) 0200-39, "Main Steam Isolation Valve Electrical Maintenance," was re-reviewed and re-field-verified for both units. It was then checked by the Senior Work Analyst for the Electrical Maintenance Department. No similar configuration discrepancies were identified.

The individuals involved in the wiring discrepancies were counseled by the Master Electrician. Also, this event was reviewed with Electrical Maintenance Department personnel to stress the importance of performing effective field verification of procedures.

**CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATION - Example b**

Procedure DES 0200-39, will be revised to include a precautionary statement emphasizing that the field side of the AC terminal blocks in the panels in the Control Room shall have no more than one lead per terminal. This procedure will be revised by June 1, 1992.

**DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED - Example b**

Full compliance was achieved with review and field verification of the surveillance procedure.

VIOLATION: (237/92002-03)

Technical Specification 3.1.A and Table 3.1.1 requires a minimum of three operable intermediate range monitors operable in each reactor protection trip channel while in Refuel Mode.

Contrary to the above, on February 2, through February 3, 1992, only two intermediate range monitors were operable in reactor protection trip channel B while Unit 2 was in Refuel Mode.

REASON FOR VIOLATION:

On February 1, 1992, an Instrument Mechanic (IM) Control System Technician (CST) obtained a copy of Dresden Instrument Surveillance (DIS) 0700-04, "IRM Rod Block/Scram Calibration Test. DIS 0700-04 includes checking a number of alarms for each IRM channel. The surveillance includes removal of the supply cable from the detector drawer to facilitate annunciator diagnostics and cable reconnection prior to returning the monitor to service. After performing the surveillance, the CST failed to properly reconnect the high voltage cable for IRM 17, thus rendering IRM 17 inoperable. The CST did not verify the reconnection of the high voltage cable, and the surveillance procedure did not require an independent or second verifier.

On February 2, 1992, IRM 15 was bypassed leaving only two of the required three IRMs operable. On February 3, 1992, a Nuclear Quality Program Inspector observed the disconnected cable on IRM 17 and reported this condition to the Senior Control Room Supervisor. The cable was immediately reconnected. A visual verification was performed of the other IRM and Source Range Monitor high voltage connectors to ensure that they were in the locked position.

Contributing to this event was the station's understanding of the scope of an adequate independent verification program for surveillance testing. In response to NUREG 0737, Item I.C.6, Dresden committed to implement a limited independent verification for surveillance testing following the staffing of the Senior Control Room Supervisor position. This was applied to operations related activities. Consistent with this, Information Notice (IN) 84-51 was understood to apply to operations related activities and surveillances which involved valve manipulation. It was believed that the IN was not related to lifted leads; therefore, the independent verification program was not modified.

The Dresden Station Procedure Writer's Guide provides directions on the inclusion of independent verification for surveillances. Specifically, for Dresden Instrument Surveillances, Section 7.1.4.3.1 of the Writer's Guide requires, "An independent verification of proper safety related system line up shall be performed following surveillance testing. This may be accomplished by functional testing, use of a second qualified operator or automatic system status monitoring." Station procedures that have been upgraded using the Writer's Guide have this verification requirement. DIS 0700-04 had not been processed through the upgrade program; therefore, the verification requirement was not included in the surveillance.

**CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED:**

The CST was counseled by the Production Superintendent on the importance of self-checking. The IM department reviewed other work performed by the CST and found no other discrepancies.

A temporary procedure change to DIS 0700-04 was issued on February 24, 1992, to include the requirement for independent verification.

**CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATION:**

A comprehensive review of IM and EM procedures was performed to identify other procedures which should now be subject to verification. Sixteen IM and 2 EM procedures were identified as appropriate for revision to include either independent or secondary verification. Fourteen procedures have been revised. Temporary procedure changes were issued for the remaining four procedures on February 24, 1992. Permanent changes to these procedures will be completed by August 21, 1992.

The IM and EM departments conducted a review of procedures performed during the Unit 2 outage which lacked verification, and had the potential for an undetected failure to reconnect a cable or lifted lead. IM and EM staff verified that such reconnections were properly made. No other cases of failure to reconnect cable connections or lifted leads were identified. A similar review for Unit 3 was completed on April 4, 1992, prior to Unit 3 startup. No deficiencies were identified.

A temporary procedure change to DAP 9-2, "Procedure and Revision Processing" was issued on March 18, 1992, and made permanent on April 6, 1992. This refers the originator of a procedure revision or a special procedure to the independent verification requirements in accordance with DAP 07-27, "Independent Verifications." Additionally, this temporary change requires the originator to verify that changes to an upgraded procedure meet the Writer's Guide requirements.

**DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:**

Full compliance was achieved on February 3, 1992, when the high voltage cable to IRM 17 was reconnected providing three operable IRMs.