



Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

May 5, 1993

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

Attention: Document Control Desk

Subject: Dresden Nuclear Power Station Units 2 and 3
Response to Notices of Violation and Deviation
Inspection Report 50-237/93011; 50-249/93011
NRC Docket Numbers 50-237 and 50-249

Reference: 1. T.O. Martin letter to L.O. DelGeorge, dated
April 6, 1993, transmitting Inspection
Report 50-237/93011; 50-249/93011.
2. Summary Report, "Compliance to Regulatory
Guide 1.97," letter from J. Wojnarowski
(CECo) to D. Crutchfield (NRC), dated
August 1, 1985.

Enclosed is Commonwealth Edison Company's (CECo) response to
the Notices of Violation and Deviation which were transmitted
with the Reference 1 letter. The responses are provided as
attachments to this letter.

If your staff has any questions or comments concerning this
letter, please refer them to Denise Saccomando, Compliance
Engineer at (708) 663-7285.

Sincerely,

for D. Farrar
Nuclear Regulatory Services Manager

attachments

cc: A. B. Davis, Regional Administrator Region III
J. Stang, Project Manager, NRR
M. N. Leach, Senior Resident Inspector, Dresden

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ATTACHMENT 1

RESPONSE TO NOTICE OF VIOLATION

NRC INSPECTION REPORT

50-237/93011, 50-249/93011

VIOLATION: (237/93011-01; 249/93011-01)

Technical Specification 6.2.A.1 states the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2 dated February 1978, shall be established, implemented, and maintained.

Regulatory Guide 1.33 Appendix A 1.c included administrative procedures for equipment control.

Dresden Administrative Procedure (DAP) 03-05, "Out-Of-Service and Personnel Protection Cards," controls the out-of-service program with regards to equipment and personnel protection.

DAP 07-14, "Control and Criteria for Locked Equipment and Valves," governs the operation of locked valves and equipment.

Contrary to the above:

- a. On November 13, 1992, the out-of-service card for the 2A hydrogen oxygen analyzer sample pump electrical breaker was attached to the 2B sample pump breaker. This resulted in the 2B sample pump being inoperable without operations knowledge.
- b. On December 5, 1992, the 2B off gas recombiner exhaust fan was found disassembled without an out-of-service tagout.
- c. On December 14, 1992, the licensee discovered that only one of two pages of an out-of-service tagout had been hung. The out-of-service documentation showed completion on December 10. This event triggered a further review of out-of-service cards which identified other out-of-service cards hung on the wrong unit.
- d. On January 31, 1993, two out-of-service cards were found on each control switch for two low pressure coolant injection valves (2-1501-5C & 5D). One card required the valves to be open and the other card required the valves to be closed.

- e. On February 8, 1993, a contractor electrician was observed connecting a cable to an electrical breaker with only a caution card on the breaker.
- f. On February 20, 1993, an operator performing an out-of-service tagout opened the breaker feeding panel 2203-73B instead of the breaker feeding panel 2202-73B.
- g. On March 1, 1993, the Unit 3 high pressure coolant injection inlet valve to the drain bypass was found closed. The valve was required to be locked open.

REASON FOR VIOLATION:

Dresden Station has performed a detailed investigation of each cited discrepancy in the NOV and documented the events surrounding them. The investigation determined several generic contributing factors among the Out-Of-Service (OOS) errors. Most of the cited examples involved inattention to detail on the part of Dresden personnel performing the OOS work. Contributing to this problem were a cumbersome OOS procedure and a newly implemented Electronic Outage Editor. Preliminary results from an independent corporate evaluation confirm Dresden Station's findings.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED:

In instances where appropriate, the deficient OOSs were promptly corrected, resulting in the intended equipment configuration and disposition.

Dresden Administrative Procedure (DAP) 07-27, "Independent Verification", was revised to clarify the role and scope of the independent verifier.

To reinforce proactive scheduling, a memorandum was transmitted to all department heads emphasizing the importance of advance planning for out-of-services.

During a tailgate session, station management emphasized that equipment attendants who are unfamiliar with the OOS system may ask to be accompanied by another member of the Operations Department who is familiar with the system.

Shift Engineers were taught self-check training methods by the STAR (Stop, Think, Act, Review) program coordinator. Shift Engineers subsequently coached each operator on the use of self-checking techniques and formally documented that each operator

understands the self-checking process.

A tailgate was held with maintenance personnel by the ENC Supervisor to underscore the requirements of DAP 3-5, "Out of Service and Personnel Protection Cards". Particular emphasis was placed on the condition that work shall only be performed on systems and components where the isolation points have been properly labeled with OOS cards.

Personnel involved in OOS errors were counseled on management expectations for procedural adherence and attention to detail. In addition, two individuals involved in OOS problems were required to present a tailgate session emphasizing error avoidance in the OOS process and management's expectations for performing self check.

A tailgate session stressing the necessity to enforce self-checking was performed by station management for Operations personnel.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATION:

For all OOS events from November 1992 to April 1993, Dresden Station performed an extensive root cause evaluation to review and address station-wide OOS errors. Included in this evaluation was a review of OOS-related scheduling problems and work practices. Preliminary findings indicate the potential for improvement in the areas of scheduling, procedures, communications, and self-checking. Results from this evaluation will be issued by May 20, 1993, and a comprehensive Action Plan to address noted deficiencies will be developed by June 18, 1993.

In order to obtain an independent perspective on the OOS issue at Dresden, CECO's Corporate Performance Assessment Group conducted a Human Performance review of Dresden's OOS program from April 12 through April 21, 1993. The Assessment Group consisted of four individuals, three of whom worked formally at INPO and one of whom was previously a shift control room engineer. This review included an assessment of Operations Planning and Scheduling techniques, Operator OOS training, OOS approval cycles, and field implementation of OOSs. Observations and recommendations from this review will be issued by May 21, 1993. Dresden Station will evaluate these observations and recommendations, and corrective actions will be integrated into the Comprehensive Action Plan noted above.

The Corporate OOS Production Instructions, which DAP 03-05 implements, are currently being evaluated by a cross-section of station and corporate personnel for inconsistencies and

enhancements. Appropriate revisions identified under this review will be included in DAP 03-05.

Dresden Station will review the Outage Editor database for potential discrepancies and make appropriate corrections by September 30, 1993.

At the Operating Department's request, Failure Prevention, Inc. (FPI) is providing a seminar to a multi-disciplinary group of station and corporate personnel. This comprehensive course includes training on root cause analysis and diagnostic techniques for organizational and programmatic improvements. Dresden Station's OOS issues were specifically selected to be utilized for the case study of this course. Dresden is currently discussing the benefits of having FPI perform an extensive organizational and programmatic diagnostic of the OOS process.

To measure and evaluate the effectiveness of improvement initiatives, Dresden Operations will lead reviews of the OOS process during the first and fourth quarters of 1994.

DATE OF FULL COMPLIANCE:

Full compliance was achieved when the improperly placed OOSs were corrected.

ATTACHMENT 2

RESPONSE TO NOTICE OF DEVIATION

NRC INSPECTION REPORT

50-237/93011, 50-249/93011

DEVIATION: (237/93011-04; 249/93011-04)

The Reference 2 Summary Report, "Compliance to Regulatory Guide 1.97," was submitted by licensee letter J. Wojnarowski, CECo, to D. Crutchfield, NRC, dated August 1, 1985. In that report, the licensee committed to use the torus area radiation detectors for the primary containment radiation monitors specified in Regulatory Guide 1.97, Revision 3, "Instrumentation for Light-Water-Cooled Nuclear Power Plants to Assess Plant Conditions During and Following an Accident." The NRC concluded in letter M. Grotenhuis, NRC, to L. Butterfield, CECo, dated August 31, 1987, that the licensee provided an explicit commitment on conformance to Regulatory Guide 1.97.

Contrary to the above, since January 1989, the torus area radiation monitors have been inoperable.

REASON FOR DEVIATION:

The Reference 2 Summary Report specified that both torus radiation monitoring and drywell high range radiation monitoring were available for the Regulatory Guide 1.97 primary containment area radiation monitoring function. While it was known since January of 1989 that the torus radiation monitors were not operational, it appears that the NRC was never formally notified of the Reg. Guide 1.97 commitment change. It is believed that the March 27, 1989, version of the Reg. Guide 1.97 Variable List, which correctly identified that the torus area radiation detectors were out-of-service and that the drywell monitors were being used instead, was made available to the NRC during the May 1990, Reg. Guide 1.97 Conformance audit of Dresden Station. However, there was no discussion of this issue in the NRC inspection report for this audit.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED:

In April 1992, a formal evaluation for the disconnection of the torus area radiation monitors was performed. This evaluation determined that the torus area radiation loops 2(3)-2418, C, and D should be removed from service and deleted from the Reg. Guide 1.97 Variable List. The drywell radiation monitor alone satisfies the primary containment area radiation monitoring function specified in Reg. Guide 1.97. Accordingly, Dresden Station has maintained compliance with the recommendations from Reg. Guide 1.97 pertaining to primary containment area radiation monitoring.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER DEVIATION:

Procedure ENC-QE-12.1, "Classification and Listing of Safety-Related Structures, Systems, Components, and ASME Section III Components for Dresden and Quad Cities Stations" currently establishes the method for controlling entries to the Safety-Related Classification List (SCRL) and MEL. To ensure that changes to Reg. Guide 1.97 components are properly reviewed for NRC notification, a revision will be made to the Engineering and Construction procedure which controls the Master Equipment List (MEL) by August 31, 1993. A requirement will be added to this procedure to ensure that the Regulatory Assurance Department is consulted for proper determination of NRC notification for changes made to the SCRL/MEL involving Reg. Guide 1.97 components.

DATE OF FULL COMPLIANCE:

This Deviation Response notifies the NRC that Dresden Station no longer utilizes the torus area radiation monitors to meet the recommendations of Reg. Guide 1.97, as originally documented in the Reference 2 report. As described above, the drywell radiation detectors and monitors alone are sufficient to meet the Reg. Guide 1.97 recommendations. Full compliance will be achieved upon the NRC's receipt of this Deviation response.