Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

October 27, 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 Notice of Violation; Inspection Report 50-237/93020; 50-249/93020
NRC Docket Numbers 50-237 and 50-249

Reference: E.G. Greenman letter to M.J. Wallace, dated September 27, 1993, transmitting Inspection Report 50-237/93020; 50-249/93020.

Enclosed is Commonwealth Edison Company's (CECo) response to Notice of Violation 50-237(249)/93020 as requested in the referenced letter.

If your staff has any questions concerning this letter, please refer them to Sara Reece-Koenig, Regulatory Performance Administrator at (708) 663-7250.

Sincerely,

D. Farrar
Nuclear Regulatory Services Manager

Attachments

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

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ATTACHMENT
RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
50-237/93020; 50-249/93020

VIOLATION:

10 CFR 50, Appendix B, Criterion II, "Quality Assurance Program", required in part, that control be provided over activities affecting the quality of the identified structures, systems, and components to an extent consistent with their importance to safety. Activities affecting quality shall be accomplished under suitably controlled conditions. Controlled conditions include the use of appropriate equipment, suitable environmental conditions for accomplishing the activity, such as adequate cleanliness, and assurance that all prerequisites for the given activity have been satisfied.

Contrary to the above:

a. On July 14, 1993, management failed to ensure adequate cleanliness of the Unit 3 drywell prior to closeout.

b. On July 16, 1993, management failed to control activities in the Unit 2 reactor building in that there were numerous examples of unattended, unsecured portable (i.e., on wheels) equipment alongside safety related motor control centers and the access stairway to the Unit 2 east low pressure coolant injection and core spray room.

c. During the period July 16 through 30, 1993, management failed to control scaffolding erection and maintenance activities in the Unit 2 west low pressure coolant injection and core spray corner rooms. Specifically, unsecured equipment including: scaffold material, two electric motors, and a ladder, were left unattended.

REASON FOR VIOLATION:

Inattention to detail and assigning minimal safety significance to the listed items resulted in the violation.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED:

Expectations regarding the conduct of drywell closeout activities was reinforced with Operations.

As specific items were brought to management attention, appropriate corrective actions were taken.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATION:

Material Condition Area Inspector positions have been created, with position expectations proceduralized.

A Material Condition Coordinator has been assigned to the Maintenance Staff, and a procedure defining expectations for material conditions rounds has been developed for every Area Inspector.

A twelve week rolling schedule has been developed to help prioritized work and ensure that planning and resource allocation for the job is effectively implemented. This will ensure timely actions are pursued based upon the safety significance. This methodology has been proceduralized to ensure consistent application of the rolling schedule.

The Shift Operations Supervisor is presently rotating shifts to ensure that management expectations are communicated and understood on all shifts and to determine how the expectations are being implemented. A licensed shift supervisor is personally participating in the rounds activities to ensure that the rounds are implemented in a consistent and effective manner.

On August 10, 1993, the Station Manager conducted a meeting in which department head expectations were defined. The agenda for the meeting included the following topics:

* establishing expectations
* communicating the expectations
* holding people accountable for meeting the expectations

Additionally, the following issues were discussed:

* number of industrial safety accidents
* material condition and housekeeping
* personnel performance

The Station Manager and Chief Union Steward are conducting communication meetings between department heads and bargaining unit stewards. These meetings are designed to open lines of communication and reinforce standards and expectations, as well as reviewing accountability measures for all site personnel.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Dresden is in full compliance.

VIOLATION:

Dresden Technical Specification 6.2.A.1 stated that 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, operation, and shutdown of safety related systems.

a. Dresden Operating Procedure (DOP) 4400-08, "Circulating Water System Flow Reversal," required condenser suction back pressure of less than four inches mercury prior to initiating a flow reversal.

Contrary to the above, the prerequisites to DOP 4400-08 did not include adequate qualitative criteria to perform the task and resulted in a Unit 3 automatic shutdown from a loss of condenser vacuum on July 10, 1993.

b. Dresden Administrative Procedure (DAP) 07-27, "Independent Verifications," required as a minimum, independent verification of all fuses used in safety related systems. DAP 07-27 also required that independent verification (IV) be documented on the IV Log Sheet when no other procedural sign-off existed.

Contrary to the above, prior to August 14, 1993, fuses used in safety related systems were removed and placed back in service without independent verification during ground detection activities.

c. Dresden Electrical Surveillance (DES) 6600-05, "Dresden Diesel Generator One Month Electrical surveillance Inspection," required the immersion heater current to be approximately 17 amps.

Dresden Administrative Procedure 09-11, Conduct of Surveillance, Special, and Complex Procedures," required the generation of a problem identification form and the prompt notification of the shift engineer or designee when the procedural results were found outside of those designated in the procedure.

Contrary to the above, on July 8, 1993, electrical maintenance personnel failed to initiate a problem identification form, and failed to promptly notify the shift engineer when the acceptance for the immersion heater current was not met.

VIOLATION: (Continued)

d. Dresden Administrative Procedure 07-05, "Operating Logs and Records," required degraded or inoperable equipment to be logged in the Degraded Equipment Log.

Contrary to the above, on July 20, 1993, the operating authority authorized work on a Unit 2 source range monitor but failed to document the inoperable status in the Degraded Equipment Log.

e. Dresden Radiological Procedure (DRP) 1460-01, "Routine Personnel Decontamination," stated that personnel contamination levels less than 100 counts per minute (cpm) above background shall be recorded in the Contamination Log.

Contrary to the above, on July 16, 1993, and on several other occasions throughout the inspection period, radiation technicians failed to document shoe contamination events in the Contamination Log.

REASON FOR VIOLATION:

Inattention to detail associated with procedural usage and adherence resulted in this violation.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED:

a. LER 3-93-014 was written to document the reactor scram on Unit 3 and included the following:
   * DOP 4400-08 did not give adequate guidance to ensure sufficient margins were available to conduct the flow reversal.
   * As an interim measure a temporary procedure change was written delineating the minimum condenser vacuum required prior to performing flow reversal.
   * DOP 4400-08 was revised incorporating the temporary procedure change delineating the minimum condenser vacuum required prior to performing flow reversal.

b. Regarding independent verification associated with the removal and replacement of fuses for ground checking.
   * The operating procedure controlling 125 VDC ground checking (DOP 6900-06) did not clearly identify the requirements associated with independent verification of fuses.
   * The operating procedure controlling 125 VDC ground checking (DOP 6900-06) have been revised to clarify the requirements for independent verification of fuses.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED: (Continued)

c. Relative to the adherence to acceptance criteria:
   * The workers involved with the event were counseled regarding proper procedural usage and adherence.
   * Disciplinary action was taken for not recognizing the occurrence of an abnormal situation.
   * DES 6600-05 was repeated to verify proper readings.
   * The event was tailgated emphasizing the importance of pre-job reviews.

d. Regarding the logging of inoperable equipment.
   * The inoperable equipment was immediately logged when the failure to log the degraded equipment was identified.
   * Logging expectations are continuously reinforced through coaching.

e. Relative to the issue of Radiation Protection Technicians (RPTs)documenting shoe contaminations:
   * Tailgates were conducted with department personnel regarding the requirement to document shoe contaminations.
   * A memo was issued to all RPTs and RP first line supervisors addressing the event and to reinforce the information presented in the tailgate.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATION:

A twelve week rolling schedule has been developed to help prioritize work and ensure that planning and resource allocation for the job is effectively implemented. This will ensure timely actions are pursued based upon the safety significance. This methodology has been proceduralized to ensure consistent application of the rolling schedule.

Two Level 3 Root Cause Investigations are in progress to address the numerous shoe contaminations experienced at the station, and the Resident Inspectors will be kept informed of the results.

Procedure DES 6600-05 is being revised to specify the acceptable tolerance for the immersion heater current readings. This will be completed by November 27, 1993

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATION: (Continued)

On August 10, 1993, the Station Manager conducted a meeting in which department head expectations were defined. The agenda for the meeting included the following topics:

* establishing expectations
* communicating the expectations
* holding people accountable for meeting the expectations

Additionally, the following issues were discussed:

* number of industrial safety accidents
* material condition and housekeeping
* personnel performance

The Station Manager and Chief Union Steward are conducting communication meetings between department heads and bargaining unit stewards. These meetings are designed to open lines of communication and reinforce standards and expectations, as well as reviewing accountability measures for all site personnel.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

Dresden Station is in full compliance.

VIOLATION

10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," required that measures shall be established to assure that conditions adverse to quality such as deficiencies were promptly identified and corrected.

Contrary to the above, between March 23 and July 19, 1993, a condition adverse to quality, i.e., a contaminated water leak in the 3B core spray pump room, existed and was not properly contained.

REASON FOR VIOLATION:

Inattention to detail and failure to appropriately pursue corrective actions in a timely manner resulted in the violation.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED:

Operations department personnel installed a catch containment for the identified leak.

CORRECTIVE STEPS TAKEN TO AVOID FURTHER VIOLATION:

The leak was fixed on August 4, 1993.

Material Condition Area Inspector positions have been created, with position expectations proceduralized.

A Material Condition Coordinator has been assigned to the Maintenance Staff, and a procedure defining expectations for material conditions rounds has been developed for every Area Inspector.

A twelve week rolling schedule has been developed to help prioritized work and ensure that planning and resource allocation for the job is effectively implemented. This will ensure timely actions are pursued based upon the safety significance. This methodology has been proceduralized to ensure consistent application of the rolling schedule.

The Shift Operations Supervisor is presently rotating shifts to ensure that management expectations are communicated and understood on all shifts and to determine how the expectations are being implemented. A licensed shift supervisor is personally participating in the rounds activities to ensure that the rounds are implemented in a consistent and effective manner.

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