

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-237/93024(DRP); 50-249/93024(DRP)

Docket Nos. 50-237; 50-249

License Nos. DPR-19; DPR-25

Licensee: Commonwealth Edison Company
Opus West III
1400 Opus Place - Suite 300
Downers Grove, IL 60515

Facility Name: Dresden Nuclear Power Station, Units 2 and 3

Inspection At: Morris, IL

Inspection Conducted: August 17 through October 6, 1993

Inspectors: M. Leach
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10/29/93
Date

Inspection Summary

Inspection from August 17 through October 6, 1993 (Report Nos. 50-237/93024(DRP); 50-249/93024(DRP))

Areas Inspected: Routine, unannounced resident inspection of summary of operations, operational safety verification and engineered safety feature (ESF) system walkdown, maintenance and surveillance observation, engineering and technical support observations, plant support, safety assessment and quality verification, licensee action on previous inspection findings, licensee event report review, report review, and management meetings.

Results: Of the nine areas inspected, no violations or deviations were identified in seven areas. One violation concerning failure to perform licensed operator medical evaluations was identified in paragraph 3a. One violation concerning failure to take adequate corrective actions to re-establish train separation was identified in paragraph 5a. One licensee identified non-cited violation concerning failure to perform leak detection inspections was discussed in paragraph 5b.

Assessment of Plant Operations

The inspectors observed greater management presence in the plant during the latter part of the inspection period. There were several examples where operations management showed a good safety priority and denied poorly planned maintenance activities. However, a weakness was noted in management control regarding operator medical examinations.

Assessment of Maintenance and Surveillance

The control of work activities was weak. Examples of this were: operations rejected some poorly planned activities, and the backlog of control room work requests continued to rise. The station audit of measuring and test equipment showed significant weaknesses.

Assessment of Engineering and Technical Support

Engineering involvement with the work on motor control center (MCC) 29 was poor. The effects of the proposed troubleshooting were not thoroughly reviewed prior to presentation to operations. The containment cooling service water cross tie issue showed engineering still lacked a proper safety focus. The self-identification of some missed surveillances showed an improvement in self-assessment capability.

Assessment of Plant Support

The site accountability drill was well executed and the self-assessment activities were thorough and accurate.

DETAILS

1. Persons Contacted

M. Lyster, Site Vice President
G. Spedl, Manager, Dresden Station
D. Ambler, Executive Assistant to the Site Vice President
*E. Carroll, Chemistry Supervisor
*A. D'Antonio, Site Quality Verification Supervisor
*R. Flahive, Technical Services Superintendent
L. Jordan, Health Physics Supervisor
M. Korchynsky, Senior Operating Engineer
*J. Kotowski, Operations Manager
G. Kusnik, Quality Control Supervisor
S. Lawson, Operating Engineer
*T. O'Connor, Maintenance Superintendent
*D. Pritchard, Work Control Superintendent
R. Radke, Services Superintendent
S. Reece-Koenig, Performance Assistant Administrator
J. Shields, Regulatory Assurance Supervisor
*R. Speroff, Operating Engineer
R. Stobert, Operating Engineer
*M. Strait, Technical Staff Supervisor
*D. Szumski, Master Mechanic
B. Viehl, Nuclear Engineering Design Supervisor
*B. Wong, Lead Mechanical Engineering Design
*R. Wroblewski, NRC Coordinator

* Indicates persons present at the exit interview on October 6, 1993.

The inspectors also contacted other licensee personnel including members of the operating, maintenance, plant support, and engineering staff.

2. Summary of Operations

Unit 2:

At the beginning of the report period, Unit 2 power level was administratively restricted to 730 MWe due to indicated reactor level oscillations. On September 17, the licensee tuned the indicating system to reduce the oscillation and relaxed the restriction. On September 24, the unit was derated 3% power due to feedwater flow nozzle calibration uncertainties. On September 27, the derate was reduced to 1%.

Unit 3:

Unit 3 operated at power levels up to 100% power for most of the period. On September 24, the unit was derated 3% power due to feedwater flow nozzle calibration uncertainties. On September 27, the derate was reduced to 1%.

No violations or deviations were identified.

3. Plant Operations (71707, 71710, and 93702)

The inspectors verified that the facility was being operated in conformance with the licenses and regulatory requirements and that the licensee's management control system was effectively carrying out its responsibilities for safe operation. During tours of accessible areas of the plant, the inspectors made note of general plant and equipment conditions, including control of activities in progress.

On a sampling basis, the inspectors observed control room staffing and coordination of plant activities, observed operator adherence with procedures and technical specifications, monitored control room indications for abnormalities, verified that electrical power was available, and observed the frequency of plant and control room visits by station managers. The inspectors also monitored various administrative and operating records.

Accessible portions of engineered safety feature (ESF) systems and associated support components were inspected to verify operability through observation of instrumentation and proper valve and electrical power alignment. The inspectors also visually inspected components for material conditions. Specifically, the following systems were inspected by direct field observations:

Unit 2

Standby liquid control system
2/3 standby gas treatment system
Primary containment isolation system [logic]

Unit 3

Primary containment isolation system [logic]

Plant Operations Observations

a. Licensed Operator Medical Evaluations

On August 30, the licensee's inspection of medical records identified 16 licensed personnel who had not received a medical examination within the required 2-year period of their previous medical examination. Pursuant to 10 CFR Part 55.21, each licensed operator was required to have a medical examination by a physician every two years during the period of their license. Five nuclear shift operators (NSOs) and five other operators had exceeded the due date by more than 7 months. The five NSOs were assigned licensed duties in the control room which could have permitted manipulation of the facility controls during the time period when their license would not meet required conditions as stated in 10 CFR Part 55.21.

Information Notice (IN) 91-08, "Medical Examinations for Licensed Operators," issued February 5, 1991, described problems identified by the NRC in the administration and documentation of medical examinations for licensed operators. IN 91-08 specifically identified cases where licensed operators did not receive medical examinations at two-year intervals. Furthermore, IN 91-08 also stated that each applicant for an operator license was to have a medical examination by a physician as a precondition for licensing and every two years thereafter.

Commonwealth Edison Company (CECo) corporate personnel attended an enforcement conference (Report Nos. 50-295/89040; 50-304/89036) on January 12, 1990, in which a CECo directive for the medical program identified that required licensed operator medical examinations were based on a 2-year interval following the license date. During the conference, and in the subsequent report, the NRC clearly identified that the medical examinations were required on a 2-year interval following the date that the medical examination was initially administered for individual operator licenses, and not from the date that the license was issued. Failure to perform 2-year licensed operator medical examinations is a Violation of 10 CFR 55.21 (50-237/93024-01(DRP)).

b. Fuel Limit

On September 12, a qualified nuclear engineer underestimated the local xenon transients following control rod movement and this resulted in the Unit 2 fuel design limiting ratio for center line (FDLRC) exceeding the technical specification limit of 1.0. The computer alarm for the FDLRC limit was not enabled and this problem was not identified at the time. Following discovery of the transient by a reactor engineer, a Problem Identification Form was generated. This issue is considered an Unresolved Item pending review of the licensee's evaluation (50-237/93024-02(DRP)).

c. Relay Panel Operations

On September 10, the inspectors performed a followup evaluation of the radiation shield doors in front of the standby gas treatment (SBGT) system local relay panel 2223-28A. This item was identified by operator license examiners in Inspection Report 50-237/OL-93-01(DRS) concerning access to internal components necessary to perform local operator actions. The small distance between the panel doors and the associated shield doors made it impossible to access the relays inside the panel without first removing the shield door attachment fastening bolts.

Dresden Operating Procedure (DOP) 2300-06, "High Pressure Coolant Injection System Local Manual Operation," which included the local manual start of the SBGT system, suggested starting of the B SBGT train first due to the location of the radiation shields. The

system engineer indicated that a forthcoming revision to DOP 2300-06 would include a statement specifying the tools required to access the A relay panel should local manual operation of the A SBGT system become necessary.

d. Self-Assessment Activities

Reactor operators have been performing self-assessment activities for recent operations events. This activity was in addition to the normal reporting process. The operators identified some practical methods of reducing the likelihood of personnel errors. The inspectors will continue to monitor this activity to determine its effectiveness.

One violation for failure to perform licensed operator medical evaluations was identified. One unresolved item concerning exceeding core thermal limits was identified.

4. Monthly Maintenance and Surveillance (62703 and 61726)

Station maintenance and surveillance activities were observed and/or reviewed to verify compliance with approved procedures, regulatory guides, and industry codes or standards, and in conformance with technical specifications (TS).

The following items were considered during this review: approvals were obtained prior to initiating the maintenance work or surveillance testing and that operability requirements were met during such activities; functional testing and calibrations were performed prior to declaring the component operable; discrepancies identified during the activities were resolved prior to returning the component to service; quality control records were maintained; and activities were accomplished by qualified personnel.

The inspectors observed portions of the following maintenance activities:

Unit 1

Diesel fire pump

Unit 2

2B control rod drive pump
2A stator cooling heat exchanger
2B reactor building closed cooling water (RBCCW) pump
2/3 diesel driven fire pump

Unit 3

3B RBCCW heat exchanger
3B circulating water pump
Reactor vessel level instrumentation
Replacement of 3B instrument air compressor piston and cylinder
Cleaning of service water radiation monitor receiver tank
Installation of balance-of-plant batteries
Replacement of dial position indicator for 3-1501-3B
Repair of nitrogen leak on E13 control rod drive accumulator

The inspectors also witnessed portions of the following test activities:

Unit 2

DIS 0700-10 Source Range Monitor (SRM) 23 Rod Block Calibration
DOS 1400-01 Core Spray System Pump Test
DOS 1400-05 Core Spray System Valve Operability Test
DOS 1500-02 Quarterly Containment Cooling Service Water Pump Inservice Test
DOS 1500-03 Containment Cooling Service Water Pump Test
DOS 1500-05 LPCI System Quarterly Flow Rate Test
DOS 1500-06 LPCI System Operability Test with the Torus Available
DOS 1500-10 LPCI Quarterly Pump Test for IST
DOS 2300-01 HPCI Motor Operated Valve Operability Verification
DOS 2300-08 HPCI Pump Discharge Line Temperature Monitoring
SP 93-8-74 Verification of Reactor Vessel Level Instrumentation System Narrow Range Transmitter and Feedwater Control System Operation

Unit 3

DOS 1100-01 Standby Liquid Control System Pump Test
DIS 0700-10 Source Range Monitor (SRM) 21 Rod Block Calibration
DTS 1600-12 Local Leak Rate Test (LLRT) of Containment Atmosphere Monitor Closed Loop Piping
SP 93-8-73 Operational LLRT

Maintenance and Surveillance Observations

a. Maintenance Planning for Motor Control Center 29 work

On August 26 and September 8, 1993, maintenance and technical personnel were scheduled to perform troubleshooting activities on the electrical feed to safety related motor control centers (MCC) 29-4 and 29-2. The troubleshooting activities would have rendered several safety related systems inoperable: high pressure coolant injection, one train of core spray and low pressure coolant injection, Unit 2 diesel generator cooling water, and Unit 2/3 diesel continuous lubrication pumps. Operations management denied the work authorization on both days due to incomplete planning and coordination efforts.

On August 26, operations shift management received a work package for troubleshooting and denied the work for the following reasons: no formal instructions were included in the work package and an unplanned activity would have required a 10 CFR 50.72 notification, the list of applicable TS limiting conditions of operations was incomplete, and an onsite review (OSR) to coordinate and review the proposed troubleshooting activity was not conducted.

On September 8, operations shift management received a draft copy of the OSR document to review prior to authorizing the troubleshooting later that day. The OSR stated that no dedicated diesel generators would be operable for Unit 2 during the work activity. The shift engineer again denied authorization due to the resulting plant conditions. Operations management noted that on four previous occasions the 2/3 diesel generator was not declared inoperable when the MCCs were inoperable. This oversight resulted in four missed Unusual Event classifications for loss of emergency AC power.

The inspectors had these additional concerns:

- The OSR was conducted as an individual review; no formal meeting was convened.
- The diesel generator design basis was not thoroughly reviewed prior to the OSR.
- The consequences of the Unit 2 MCC troubleshooting work on Unit 3 were not adequately considered. The 3D LPCI pump was inoperable on September 8; the inoperable 2/3 diesel generator would have resulted in a required Unit 3 shutdown within 12 hours.

The inspectors will evaluate the licensee's investigation and corrective actions during the review of the licensee's event report (LER).

b. Work Request Backlog

The inspectors noted the backlog of non-outage work requests continued to be a concern. The number of control room work requests, both outage and non-outage, was approximately 125. Such a number of outstanding work requests presented a challenge to the operators.

c. Environmental Qualification (EQ) Training

The inspectors noted that a formal EQ training program was initiated by corporate personnel in May 1992. Training was provided at two CECO plants; however, this training had not yet been provided to Dresden personnel. The inspectors were informed that classes for Dresden engineering personnel were planned for September and November 1993.

As a result of an escalated enforcement action on EQ issues in August 1990, the licensee agreed to review the previous self-initiated EQ programs, audits, and studies. The licensee performed this review and issued a report dated November 9, 1990, with a list of recommendations. One of the recommendations was "Personnel training records for EQ splice installation should be reviewed to ensure that all Dresden personnel installing electrical splices have received adequate training." The licensee's scheduled training for September and November 1993 does not include any maintenance personnel. Lack of formal EQ training for maintenance personnel was considered a weakness.

d. Inaccuracies in the Total Job Management (TJM) System

During the review of LER 89-005, several EQ work requests were obtained from the TJM system. Work requests D88682 and D88683 in the TJM system were shown as Unit 2 instead of Unit 3. On work requests D89782, D99246, and D99248, the equipment identifications in the TJM system were different from those given in the LER. These errors could lead to inadequate job planning and equipment failure trending. This was considered a weakness in the maintenance of work history.

No violations or deviations were identified.

5. Engineering and Technical Support (37700)

The inspectors evaluated the extent to which engineering principles and evaluations were integrated into daily plant activities. This was accomplished by assessing the technical staff involvement in non-routine events, outage-related activities, and assigned TS surveillances; observing on-going maintenance work and troubleshooting; and reviewing deviation investigations and root cause determinations.

Engineering and Technical Support Events

a. Concerns with Engineering Evaluation Assumptions

The licensee modified the containment cooling service water (CCSW) system to supply the control room heating, ventilation, and air conditioning system in 1985. In October 1992, this modification was reviewed and a train cross connect was identified. The licensee's corrective action was to re-establish train separation

by closing a cross-tie valve. However, as discussed in Inspection Report 50-237/93020(DRP), the licensee reopened the isolation valve following an engineering evaluation which determined the cross connection was acceptable. The sole basis for this determination was the consequences of a single failure of equipment occurring coincidentally with design basis accident. The inspectors concluded the basis for the licensee's determination was limited in scope and that the effect of single failures of equipment subsequent to the accident should also be considered in design evaluations.

Prior to the modification in 1985, the worst case postulated single failure for the CCSW system was the failure of one train to start. The modification created a dependency of one train on the other, in that the motor-operated outlet valve in the failed loop had to be closed at the time of the single failure to avoid diverting approximately 800 gallons per minute from the remaining operable low pressure coolant injection heat exchanger. With this flow diverted, the technical specification requirements would not be met. The outlet valve would have been open at the time of the single failure if either 1) the failure of one CCSW train occurred subsequent to system initiation or 2) one train was already in operation prior to system initiation. After further discussions the licensee re-closed the train cross connection valve which re-established the capability to meet single failure criteria.

The inspectors identified the following root causes:

- The failure to install check valves in the cross connection line during the 1985 modification, and
- Inadequate assumptions used in the current engineering evaluation.

The failure to take adequate corrective action following the identification of the cross connection between CCSW trains was considered a Violation of 10 CFR 50, Appendix B, Criterion XVI, corrective actions (50-237/93024-03(DRP)).

b. Failure to Perform Leak Detection Inspections

On August 9, during review of surveillance requirements, the licensee identified that Unit 3 license condition 3.I.2 leak detection inspections had not been performed for either unit since 1989. The leakage inspections were required every refueling outage for systems with the potential to transport highly radioactive fluid outside the containment after an accident. The requirement was inadvertently deleted from the Unit 2 license during the full term operating license renewal. In 1989, the licensee believed the inspections were an internal requirement, not a license condition. The inspections were dropped from the

general surveillance program (GSRV). After discovery, the licensee immediately performed the inspections on both units and found no leakage. The GSRV program was amended.

Failure to perform the inspections is considered a non-cited violation of Unit 3 license condition 3.I.2. The violation is not being cited because the criteria specified in 10 CFR 2, Appendix C, Section VII.B.(2) were satisfied.

One violation for failure to take adequate corrective actions was identified. One licensee identified non-cited violation for failure to perform leakage surveillances was noted.

6. Plant Support (71707 and 93702)

The inspectors evaluated the involvement of support organizations in assuring safe and effective plant operation. Specific areas included:

- Radiation Protection Controls

The inspectors verified that workers were following health physics procedures and randomly examined radiation protection instrumentation for operability and calibration.

- Security

During the inspection period, the inspectors monitored the licensee's security program to ensure that observed actions were being implemented according to the approved security plan. No discrepancies were identified.

- Emergency Preparedness

The inspectors verified the operational readiness of the control room technical support center and operation support center. Non-routine events were reviewed to ensure proper classification and appropriate emergency management involvement.

- Housekeeping and Plant Cleanliness

The inspectors monitored the status of housekeeping and plant cleanliness for fire protection and protection of safety-related equipment from intrusion of foreign material.

Plant Support Related Observations

a. Annual Site Personnel Accountability Drill

The inspectors observed the licensee's annual site personnel accountability drill on August 25, 1993. The licensee successfully accounted for all individuals within 20 minutes. The

newly installed card reader system enhanced the licensee's capability of obtaining a quick and accurate count of site personnel.

The inspectors also reviewed the licensee's and site quality verification critiques. The observations were appropriate and thorough. Problem identification forms were generated for discrepancies identified during the drill. The inspectors noted that information sheets which described the new card reader system were distributed to site personnel; however, the licensee did not ensure that all badged individuals received the information. The licensee subsequently redistributed the information sheets.

b. Temporary Instruction (TI) 2500/028 - Employee Concerns Program

The inspectors reviewed the licensee's employee concerns program as requested by the subject TI. On August 24, 1993, the requested information was sent to Region III. The information is attached to the report (see attachment). The inspectors did not identify any concerns.

No violations or deviations were identified.

7. Safety Assessment and Quality Verification (SAQV) (40500)

The effectiveness of management controls, verification and oversight activities in the conduct of jobs observed during this inspection were evaluated. Management and supervisory meetings involving plant status were attended to observe the coordination between departments. The results of licensee corrective action programs were routinely monitored by attendance at meetings, discussion with plant staff, review of deviation reports, and root cause evaluation reports.

SAQV Related Events

The inspectors reviewed the corrective action records (CARs) generated by the station quality verification (SQV) group. The SQV group had significant findings in the areas of measuring and test equipment, parts evaluations, locked valves, vendor manuals, and the security and fire system diesel generators. The inspectors considered the audits thorough and the findings appropriate.

No violations or deviations were identified.

8. Licensee Actions on Previous Inspection Findings (92701 and 92702)

(Closed) Violation (50-237/90020-01(DRS); 50-249/90020-01(DRS)):
Failure to qualify certain equipment components by testing and/or analysis. The inspectors reviewed the licensee's response and verified the corrective actions completed. The licensee also walked down both units. The licensee completed corrective actions for the additional EQ deficiencies identified during these walkdowns. This item is closed.

(Closed) Violation (50-237/90020-02(DRS); 50-249/90020-02(DRS)): Non-qualified terminal blocks installed in high energy line break and radiation areas. This violation also stated that some EQ related junction boxes did not contain any required weep holes. The inspectors reviewed the licensee's response and verified the corrective actions completed. The licensee also walked down both units. The licensee completed corrective actions for the additional EQ deficiencies identified during these walkdowns. This item is closed.

(Closed) Deviation (50-237/249/93011-04(DRP)): Inoperable torus area radiation monitors. Since January 1989, the torus area radiation monitors have been inoperable. The drywell radiation monitors were being used instead of the torus area radiation monitors to satisfy the requirements of Type C, Category 3 instruments in Regulatory Guide 1.97, Revision 2, "Instrumentation for Light-Water-Cooled Nuclear Power Plants to Assess Plant Conditions During and Following an Accident." The inspectors reviewed the licensee's engineering analysis of the torus area radiation monitors, DR-CID-49 and Dresden instrument surveillance (DIS) procedure 2400-03. The inspectors determined that the locations and ranges of the drywell radiation monitors satisfied the requirements for Type C, Category 3 as well as for Type E, Category 1 instruments. This item is closed.

(Closed) Unresolved Item (50-237/90016-04(DRS); 50-249/90015-04(DRS)): This item concerned the seismic and maximum credible fault testing of Moore Industries signal conditioners, used as isolation devices in some Regulatory Guide (RG) 1.97 circuits. The inspectors reviewed the Nutherm International's report Nos. CWE-3690R, revision 0, and CWE-3690MFT, Revision 0, on the tests conducted on the Moore isolators. The inspectors also reviewed the reports of Cygna Energy Services dated September 23, 1991, and Sorrento Electronics dated September 10, 1991, on the test results. These reviews indicated that the Moore isolators will function as class IE components. This item is closed.

(Closed) Unresolved Item (50-237/92020-01(DRP)): Standby gas treatment "as found" testing not performed. NRR has concluded that a visual inspection as required by ANSI N510-1975 was an acceptable approach to detecting and trending any possible degradation of charcoal filter assemblies. After further review, the inspectors determined that the licensee had met the applicable standard for testing the charcoal adsorbers and an "as found" test was not necessary. This item is closed.

(Closed) Unresolved Item (50-237/93011-03(DRP)): The licensee engineering evaluation for the containment cooling service water (CCSW) system cross connection did not consider the worst case single failure. This item is discussed in paragraph 5. This item is closed to violation (50-237/93024-03(DRP)).

(Closed) Inspector Followup Item (50-237/92010-04(DRP)): Adequacy of the isolation condenser five year heat removal capability test as performed on the Unit 3 isolation condenser. The test results as performed on Unit 3 following specific revisions to Dresden Operating Surveillance (DOS) 1300-01, "Isolation Condenser Five Year Heat Removal Capability Test," adequately met the heat rate removal requirement in accordance with the Final Safety Analysis Report Section 4.6.1.

The inspectors were concerned that the licensee's application of error analysis methods for instrumentation used to record data from such tests as the Isolation Condenser Heat Removal Surveillance, was not adequately developed or consistently applied to system testing.

Independent calculations performed by the inspectors during DOS 1300-01 indicated that as much as 30% error in the isolation condenser heat rate existed prior to the start as well as at the termination of the test. Although the isolation condenser exhibited sufficient heat removal capability, failure to account for instrument inaccuracy during the course of system testing is considered a weakness of engineering controls, especially for instruments reading in the non-conservative direction. This apparent weakness with regard to instrument error analysis was identified at the Quad Cities Nuclear Station on September 23, 1993, when feedwater nozzle flow instrument calibration deficiencies led to thermal power calorimetric calculation uncertainties and a resultant derate of 3% on each unit. This information was given to Dresden Station on September 24, 1993, where a derate of 3% was applied to both units.

Inspectors will continue to monitor licensee testing on specific systems and components for consideration as well as application of instrument error analysis. This item is closed.

(Open) Inspector Followup Item (50-237/93020-04(DRP)): 10 CFR 21 applicability for failed seals on check valves. The licensee determined that a low pressure coolant injection (LPCI) check valve failure was due to inadequate process control by the manufacturer, C&S Valve Company. The licensee identified ten dual disk check valves with Viton seal installed in the containment cooling service water, high pressure coolant injection, and LPCI systems. The licensee implemented compensatory actions to ensure continued operability. The licensee was evaluating 10 CFR 21 report applicability at the end of the inspection period.

No deviations or violations were identified.

9. Licensee Event Reports (LERs) Followup (92700)

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, immediate

corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with technical specifications.

(Closed) LER 249/89-005, Revision 02: HPCI System Declared Inoperable Due to Discovery of Cable Terminal Blocks That Were Not Environmentally Qualified. This LER is closed.

(Closed) LER 249/91008, Revision 1: Unplanned Primary Containment Group V Isolation Due to a Blown Bulb. The root cause and corrective actions to the isolation condenser valves isolation will be reviewed with Inspector Followup Item 50-237/93020-09(DRP). This LER is closed.

(Closed) LER 249/93015: A and B CCSW Pump Only Producing 6000 Gallons per Minute. This event was discussed in paragraph 5.b. of Inspection Report (50-249/93020). On August 21, 1993, the licensee successfully tested both loops. This LER is closed.

(Closed) LER (237/92-034) Revisions 0, 1, and 2: Standby Gas Treatment System Found Outside FSAR Design Limits. The inspectors reviewed the special testing of the standby gas treatment system as conducted by the engineering technical staff. Although flow data compiled during the special test could not duplicate train flows equal to or in excess of those observed during the actual event, engineering calculations have shown that offsite doses resulting from the postulated increase in SGBT flow due to a full open failure of the flow control valve, were within 10 CFR 100 and Generic Design Criteria 19 limits. This item is closed.

No violations or deviations were identified.

10. Report Review

The inspector reviewed the licensee's Monthly Plant Status Report for August 1993.

No violations or deviations were identified.

11. Management Meetings (30703)

On August 26, 1993, Mr. John B. Martin, Regional Administrator, Region III, attended a public meeting in the Training Center at the Dresden Station to discuss Dresden Station performance during the preceding month. Topics discussed included current plant status, recent staffing changes, challenges, status of Bulletin 93-03 modification to the reactor vessel level instrumentation, and system engineering performance. Mr. Martin expressed concern with the slow pace of improvement and challenged the licensee to find and resolve problems.

On September 24, Mr. William L. Axelson, Director, Division of Radiation Safety and Safeguards, Region III, was at the Dresden Station for a management meeting and tour of the facility. Items for discussion

included dose and contamination control problems identified in Inspection Report 50-237/249-93022 and improvements planned in these areas for the Unit 3 1994 refuel outage.

No violations or deviations were identified.

12. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance or deviations. One Unresolved Item disclosed during this inspection is discussed in paragraph 3b.

13. Licensee Identified Violations

The NRC uses the Notice of Violation as a standard method for formalizing the existence of a violation of a legally binding requirement. However, because the NRC wants to encourage and support licensee's initiatives for self-identification and correction of problems, the NRC will not generally issue a Notice of Violation for a violation that meets the tests of 10 CFR 2, Appendix C, Section VII.B.(2). These tests are:

- (1) it was identified by the licensee
- (2) it was not a violation that could have reasonably been corrected.
- (3) the violation was or will be corrected, including measures to prevent recurrence, within a reasonable time; and
- (4) it was not a willful violation.

One violation of regulatory requirements identified during this inspection for which a Notice of Violation will not be issued is discussed in paragraph 5b.

14. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in paragraph 1) throughout the inspection period and at the conclusion of the inspection on October 6, 1993, to summarize the scope and findings of the inspection activities. The licensee acknowledged the inspectors' comments. The inspectors also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspectors during the inspection. The licensee did not identify any such documents or processes as proprietary.

Attachment: Temporary Instruction 2500/028, Appendix A.

Attachment

EMPLOYEE CONCERNS PROGRAMS

PLANT NAME:	<u>LaSalle</u>	Licensee:	<u>CECO</u>	DOCKET #:	<u>50-373;374</u>
	<u>Dresden</u>		<u>CECO</u>		<u>50-237;249</u>
	<u>Quad Cities</u>		<u>CECO</u>		<u>50-254;265</u>
	<u>Byron</u>		<u>CECO</u>		<u>50-454;455</u>
	<u>Braidwood</u>		<u>CECO</u>		<u>50-456/457</u>
	<u>Zion</u>		<u>CECO</u>		<u>50-295/304</u>

NOTE: Please underline yes or no if applicable and add comments in the space provided.

A. PROGRAM:

1. Does the licensee have an employee concerns program?
(Yes or No/Comments)

The licensee conducts a Quality First program to identify and address employee concerns. Other programs such as the vision through quality (VQ) search for opportunity (SFO) exist. The VQ SFO program is more oriented toward identifying and developing improvement initiatives versus a formal program for raising specific safety issues. Therefore, the completion of this form will deal only with the QF program.

2. Has NRC inspected the program? Report # _____

The NRC had not recently inspected this program.

B. SCOPE: (Circle all that apply)

1. Is it for:
 - a. Technical? (Yes, No/Comments)
 - b. Administrative? (Yes, No/Comments)
 - c. Personnel issues? (Yes, No/Comments)

The concerns are categorized as security, quality, and management but may, in fact, involve any of the above.

2. Does it cover safety as well as non-safety issues?
(Yes or No/Comments)
3. Is it designed for:
 - a. Nuclear safety? (Yes, No/Comments)
 - b. Personal safety? (Yes, No/Comments)

- c. Personnel issues - including union grievances?
(Yes or No/Comments)

Although it can involve personnel issues, it does not deal with union grievances.

4. Does the program apply to all licensee employees?
(Yes or No/Comments)

5. Contractors?
(Yes or No/Comments)

This program is not necessarily stressed to contract employees the licensee believes are not in a position to identify Quality First issues such as parking lot pavers.

6. Does the licensee require its contractors and their subs to have a similar program?
(Yes or No/Comments)

CECo administers the entire program.

7. Does the licensee conduct an exit interview upon terminating employees asking if they have any safety concerns?
(Yes or No/Comments)

Upon termination, employees are given concern disclosure statements to complete. Exit interviews are given. The percentage of terminating employees receiving them is drastically reduced due to a reduction in program manpower since the beginning of the year.

C. INDEPENDENCE:

1. What is the title of the person in charge?

Quality First Administrator (QFA)

2. Who do they report to?

Director of Station Quality Verification

3. Are they independent of line management?

Yes-Reports through offsite quality verification organization

4. Does the ECP use third party consultants?

No-However, quality verification personnel have been utilized to do interviews. The QFA determines the appropriate group to do the investigation.

5. How is a concern about a manager or vice president followed up?

This would be decided on a case by case basis.

D. RESOURCES:

1. What is the size of staff devoted to this program?

Since the beginning of the year, staff has been cut to one individual for all six CECO plants.

2. What are ECP staff qualifications (technical training, interviewing training, investigator training, other)?

No specific qualifications exist for the QFA, who has been involved in the program a number of years. Guidelines for interviewers are available but there are no specific qualifications.

E. REFERRALS:

1. Who has followup on concerns (ECP staff, line management, other)?

The QFA may do the followup himself or assign it to another group including line management.

F. CONFIDENTIALITY:

1. Are the reports confidential?
(Yes or No/Comments)
2. Who is the identity of the allegor made known to
(senior management, ECP staff, line management, other)?

Information on the allegor identity remains with QFA.

3. Can employees be:
 - a. Anonymous? (Yes/No Comments)
 - b. Report by phone? (Yes, No/Comments)

A toll free number is available.

G. FEEDBACK:

1. Is feedback given to the allegor upon completion of the followup?

(Yes or No - If so, how?)

Feedback is given by mail or telephone.

2. Does program reward good ideas?

No

3. Who, or at what level, makes the final decision of resolution?

This is determined by QFA in conjunction with line management.

4. Are the resolutions of anonymous concerns disseminated?

No

5. Are resolutions of valid concerns publicized (newsletter, bulletin board, all hands meeting, other)?

No

H. EFFECTIVENESS:

1. How does the licensee measure the effectiveness of the program?

Not measured

2. Are concerns:

- a. Trended? (Yes or No/Comments)

There are too few official "Records of Concern" (ROC) to warrant trending. The QFA does informally look for common concerns on items which do not warrant official ROCs.

- b. Used? (Yes or No/Comments)

Corrective actions are addressed in the program.

3. In the last three years how many concerns were raised? Closed? What percentage were substantiated?

The QAF screens comments and identifies those to be handled as official Records of Concern" (ROC).

The following data is for ROCs from 1990 through August 1993. No formal ROCs have been initiated thus far in 1993.

	<u>#Closed</u>	<u>%Substantiated</u>
LaSalle	2	100
Byron	9	22
Braidwood	6	33
Quad Cities	3	3
Dresden	4	25
Zion	1	0

Comments received during or after a refuel outage that the QAF determines do not warrant an official ROC are compiled and transmitted to plant management for information. This occurs several months after the outage.

4. How are followup techniques used to measure effectiveness (random survey, interviews, other)?

No followup techniques utilized except perhaps for contractors they see multiple times at different CECO sites.

5. How frequently are internal audits of the ECP conducted and by whom?

There are no audits of this area. The onsite quality verification superintendent is responsible for reviewing information copies of quality ROCs to determine if additional QA reviews are warranted.

I. ADMINISTRATIVE/TRAINING:

1. Is ECP prescribed by a procedure? (Yes or No/Comments)

Nuclear Operations Directive (NOD)-OA.12, "Quality First Program Directive"

2. How are employees, as well as contractors, made aware of this program (training, newsletter, bulletin board, other)?

The program is briefly described in Nuclear General Employee Training (NGET). It may also be mentioned in occasional safety meetings or departmental tailgates.

ADDITIONAL COMMENTS:

(Including characteristics which make the program especially effective or ineffective.)

In viewing the number of official "Records of Concerns (ROC)," that are formally tracked, investigated, and resolved, the effectiveness of the program is questionable. No ROCs have been generated thus far for 1993. This may be

partially related to the staff reduction and availability of personnel to conduct exit interviews. Due to the lack of resources, some concerns which would have been handled as official ROCs in previous years are now being handled more informally.

The person completing this form please provide the following information to the Regional Office Allegations Coordinator and fax it to Richard Rosano at 301-504-3431.

NAME:

TITLE:

PHONE #:

David E. Hills/Senior Resident Inspector/815-357-8611

DATE COMPLETED: 9-6-93