



Commonwealth Edison
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July 27, 1981

Mr. James G. Keppler, Director
Directorate of Inspection and
Enforcement - Region III
U.S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Subject: Dresden Units 2 and 3
Response to I.E. Inspection
Report No. 50-249/80-29
NRC Docket No. 50-249

Reference (a): J. G. Keppler letter to Cordell Reed
dated July 2, 1981.

Dear Mr. Keppler:

Reference (a) transmitted the results of a special inspection conducted on December 21-23 and 31, 1980, at our Dresden Nuclear Power Station Unit 3. Appendix A to Reference (a) identified two items of non-compliance with NRC requirements. The Commonwealth Edison Company response to those items of non-compliance are provided in Attachment A to this letter. With regard to the concerns expressed in Reference (a), we agree that it is unacceptable for the transition from cold to hot shutdown to occur and go unnoticed by the operating crew for several hours. We have made this very clear to the personnel involved, and we have also reviewed the occurrence with each operating crew.

Concerning Item 1 of your cover letter summation of significant factors contributing to the event, the procedure for use of shutdown cooling has been revised to assure that specific attention is given to those control room indications that would provide early detection of any future similar events. The Shift Control Room Engineers, who were not formally in place at the time of the occurrence, are expected to provide a further independent review of control room indications, to ensure that such events do not go undetected.

Items 2 and 3 of your summation seem to indicate that previous operating experience should have revealed the potential for such an occurrence. We are not aware of any previous experiences that should have provided such foresight. A review of several other BWR plant procedures and systems by company personnel revealed that other plants did not appear to have similar occurrences. In fact, review of the event by both General Electric and NSAC has resulted in issuance of SIL 357 by G.E. and has precipitated plans to issue a Significant Operating Experience Report by INPO/NSAC.

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Our review of the occurrence and the review by G.E. and INPO has not disclosed any deficiency in outage preplanning, based on information available at the time. None of the reviews have concluded that one source of decay heat removal is inadequate, if the system is operated according to the procedures now known, i.e. at least one Shutdown Cooling Pump operating at rated flow.

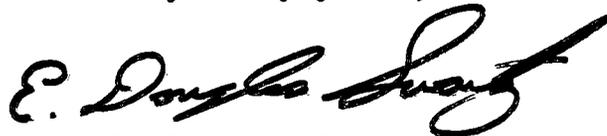
We agree that any outage preplanning activities must, in light of the information now known, include a review of system alignments that could potentially cause a similar event. In addition, we agree that our procedure for the use of shutdown cooling must reflect, as it now does, the indications that are critical for early detection of a similar event.

We believe the procedural changes that we have made and the training we have conducted provide reasonable assurance that a similar event will not recur.

To the best of my knowledge and belief, the statements contained herein and in the attachments are true and correct. In some respects, these statements are not based upon my personal knowledge but upon information furnished by other Commonwealth Edison employees. Such information has been reviewed in accordance with Company practice and I believe it to be reliable.

Please address any questions you may have concerning this matter to this office.

Very truly yours,



E. Douglas Swartz
Nuclear Licensing Administrator

cc: Region III Inspector - Dresden

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SUBSCRIBED AND SWORN to
before me this 27th day
of July, 1981.


Notary Public

Attachment

ATTACHMENT A

COMMONWEALTH EDISON COMPANY
RESPONSE TO NOTICE OF VIOLATION

The items of non-compliance identified in Appendix A of the Reference (a) NRC letter, dated July 2, 1981, are responded to in the following paragraphs:

1. Technical Specification 3.7.A.2 requires primary containment integrity be maintained at all times when the reactor water temperature is greater than 212°F and fuel is in the reactor vessel.

Contrary to the above, over a period of up to six hours on December 20-21, 1980, while fuel was in the reactor vessel and while primary containment integrity was not established (personnel access doors were open), the reactor water temperature exceeded 212°F.

CORRECTIVE ACTION AND RESULTS ACHIEVED

Primary Containment Integrity was immediately reestablished and a second Shutdown Cooling Pump was started to reduce reactor coolant temperature to less than 212°F.

CORRECTIVE ACTION TAKEN TO AVOID FURTHER NON-COMPLIANCE

Procedure DOP 1000-3, Shutdown Cooling Mode of Operation, was revised to include cautions regarding the possibility of reactor pressurization under conditions of low recirculation flow. The procedure now includes specific instructions relating to critical control room instrumentation to detect stratification and resultant reactor pressurization. In addition, possible modifications are currently under review by our Station Nuclear Engineering Department to make control of reactor water temperature possible by throttling the flow rate of cooling water through the Shutdown Cooling Heat Exchanger rather than throttling the flow of reactor coolant through the heat exchanger. The addition of alarms to identify conditions that could result in stratification and pressurization, are also under review.

DATE WHEN FULL COMPLIANCE WAS ACHIEVED

Full compliance was achieved on December 21, 1980, at 0505 a.m. when Primary Containment Integrity was reestablished. The change to DOP 1000-3 was approved for use on December 31, 1980.

2. 10 CFR 50.72(a)(5) requires notification of the NRC within one hour of any event requiring initiation of shutdown in accordance with Technical Specification Limiting Conditions for Operation. The exceeding of Technical Specification 3.7.A.2 as described in Item 1 required the initiation of actions to place the plant in a cold shutdown condition until primary containment integrity was established.

Contrary to the above, although primary containment was promptly established five minutes after the event described in Item 1 was identified, the NRC was not notified of the event until approximately two hours and twenty minutes after the conditions were identified.

CORRECTIVE ACTION AND RESULTS ACHIEVED

The failure to notify the NRC within one hour per 10 CFR 50.72(a)(5) was a result of a misunderstanding over interpretation of the requirements. In the past, we had understood that we were to be sure that we had an event requiring notification before initiating the notification process based on preliminary information. An example of this occurred when we were advised that for low activity effluent samples, it was permissible to use a long enough count time to ensure good statistics, rather than shorten the count time; and erroneously report an unplanned release.

Concerning the December 21, 1980, event, the Unit 3 Operating Engineer who decided not to immediately report the occurrence was initially unsure as to the cause of the conflicting reactor pressure and recirculation water temperature indications. He elected to take the time to analyze the indications and rule out possible causes such as instrument failure, prior to reporting the event. The event was, however, reported immediately, once it was determined that an event meeting the criteria of 10 CFR 50.72 had occurred.

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER NON-COMPLIANCE

As a result of the concerns expressed at the Enforcement Conference, we have reviewed and stressed the one hour reporting requirement with the applicable personnel. We intend to meet the strict interpretation and report as soon as possible after ensuring the safe operating condition of the unit.

DATE OF FULL COMPLIANCE

We believe full compliance has been achieved.