Commonwealth Edison
One First National Plaza, Chicago, Illinois
Address Reply to: Post Office Box 767
Chicago, Illinois 60690 - 0767

June 22, 1988

Mr. A. Bert Davis
Regional Administrator
U.S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

Subject: Dresden Station Units 2 and 3
Response to Inspection Report Nos.
50-237/88006 and 50-249/88007
NRC Docket Nos. 50-237 and 50-249

Reference: W.L. Forney letter to Cordell Reed dated
May 25, 1988

Dear Mr. Davis:

The referenced letter documents the results of a routine safety inspection conducted by Messrs. S.G. DuPont and P.D. Kaufman of your office on March 18 through May 9, 1988 of activities at Dresden Nuclear Power Station, Units 2 and 3.

During the course of that inspection, certain activities appeared to be in noncompliance with NRC requirements. Attachments A and B to this letter contain our responses to the violations.

Commonwealth Edison understands the significance of the issues identified in the Notice of Violation and has implemented corrective actions to prevent recurrence.

If there are any further questions regarding this matter, please contact this office.

Very truly yours,

H. E. Bliss
Nuclear Licensing Manager

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Attachment

cc: B.L. Siegel - Project Manager, NRR
S.G. DuPont - Senior Resident Inspector, Dresden

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ATTACHMENT A

COMMONWEALTH EDISON COMPANY

REPLY TO NOTICE OF VIOLATION

SEVERITY LEVEL IV

VIOLATION

10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings", as implemented by Commonwealth Edison Company's Quality Assurance Manual, Quality Requirement 5.0, requires that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings appropriate to the circumstances.

Contrary to the above, the procedures or instructions that were in place to control rigging activities that could affect quality were found to be inadequate:

Dresden Maintenance Procedure DMP 5800-3, Revision 3, "Safe Rigging Practices", was inadequate because it did not specify what apparatus a chain fall can be attached to or suspended from whenever lifting loads. This resulted in a broken nitrogen makeup supply line to both Unit 2 and 3 and declaration of an Unusual Event on April 29, 1988.

DISCUSSION

The damage to the Primary Containment Nitrogen Inerting Makeup System line (2-8505-1 1/2-T) occurred during rigging operations involved with the reinstallation of Unit 3 containment vent and purge system valve 3-1601-20B. A sling and come-along were slung over the 16 inch Containment Cooling Service Water line and inadvertently over an adjacent 1 1/2 inch nitrogen inerting makeup line. While using the sling/come-along assembly to move valve 3-1601-20B into proper horizontal alignment, the nitrogen inerting makeup system line was inadvertently damaged.

The cause of this event was attributed to personnel error due to inattention to detail during the rigging operation. A contributing factor involved a rigging procedure deficiency. This is the first event involving initiation of a unit shutdown due to Nitrogen Inerting/Makeup System piping damage. (Reference LER #88-006-0)

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

The Unusual Event was initially declared at 0440 hours on April 29, 1988. This event was cancelled at 0640 hours on the same date, when an alternate nitrogen inerting makeup supply was placed into service.

Immediate corrective actions involved repair of the damaged nitrogen inerting makeup system line under Work Request 74709 and returning the system to normal service.

CORRECTIVE ACTION TAKEN TO AVOID FURTHER NONCOMPLIANCES

The event was discussed at a Mechanical Maintenance Department (MMD) tailgate meeting on May 5, 1988. Maintenance Memorandum #40 was issued on May 25, 1988 regarding proper rigging practices. This memo provides interim guidance until the Station procedure on rigging can be formally revised. Among other constraints, the memo forbids rigging or lifting from plant systems or components without a specific evaluation from the station's Technical Staff. To further enhance awareness of this memo, it was formally presented at the June 16, 1988 MMD tailgate meeting. A formal station tailgate will be held by all station departments, including Project and Construction Services and Substation Construction. Dresden Maintenance Procedure (DMP) 5800-3, Safe Rigging Practices is being revised and is scheduled for completion by August 5, 1988. Supplemental training on rigging activities will also be provided to Mechanical and Electrical Maintenance personnel during the first cycle of continuing maintenance training in 1989.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED FOR ALL ITEMS

The immediate corrective actions, a discussion of the event at a MMD tailgate meeting, issuance of Maintenance Memo #40, and a subsequent awareness tailgate have been completed. A formal station tailgate session of the event is scheduled for June 23, 1988. The revision to Dresden Maintenance Procedure (DMP) 5800-3 is scheduled for completion by August 5, 1988. Additional training will be complete at the end of the first cycle of continuing maintenance training in 1989.

ATTACHMENT B

COMMONWEALTH EDISON COMPANY

RESPONSE TO NOTICE OF VIOLATION

SEVERITY LEVEL V

VIOLATION

10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings", as implemented by Commonwealth Edison Company's Quality Assurance Manual, Quality Requirement 5.0, requires that activities affecting quality shall be accomplished in accordance with documented instructions and procedures.

Contrary to the above, the Unit 2 Nuclear Shift Operator (NSO) failed to follow the procedure and adjust the High Pressure Coolant Injection (HPCI) pump discharge flow to 5000 gpm via the HPCI flow controller per Dresden Operating Surveillance Procedure DOS 2300-6, "Monthly HPCI System Pump Test for In-Service (IST) Program," on April 4, 1988. This resulted in the IST results exceeding the HPCI pump discharge high flow limit of 5325 gpm and the system being declared inoperable.

DISCUSSION

Dresden Operating Surveillance Procedure DOS 2300-6, "Monthly HPCI System Pump Test for In-Service Test (IST) Program," requires the adjustment of the High Pressure Coolant Injection (HPCI) pump discharge flow to 5000 gpm using the HPCI flow controller. This step was inadvertently missed by the NSO resulting in the IST exceeding the HPCI pump discharge high flow limit of 5325 gpm, thereby causing the system to be declared inoperable.

HPCI Surveillance Procedures DOS 2300-1, DOS 2300-3 and DOS 2300-6 are structured such that they are performed concurrently in order to limit unnecessary wear on components. Because the steps required for each activity are not identical, it is necessary to fulfill the requirements of each individual procedure while performing them concurrently. Each of these procedures is a separate document capable of being performed without benefit of the others. This caused the critical step in question to be overlooked.

In addition, shift supervision is required to review IST surveillances upon completion to ensure that the appropriate IST guidelines have been satisfied. If any IST parameters have not been satisfied, the equipment is to be immediately declared inoperable and appropriate actions taken in accordance with the Technical Specifications and reporting requirements. In this case, the Station Control Room Engineer (SCRE) did not thoroughly review the completed surveillance, and thus discover the IST data discrepancy until performing the final review of the IST documentation. Had this review been performed in a more timely manner, the improper setting of the HPCI flow would have been discovered during performance of the surveillance and appropriate direction given to the NSO.

Based on the factors listed above, the root cause of this event was determined to be procedure deficiency with contributing factors of personnel errors. These errors were on the part of the SCRE regarding timely review of completed IST surveillances and the NSO in that the procedure step requiring adjustment of the flow controller to 5000 gpm was inadvertently missed.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

Upon discovery of the error by omission of the flow adjustment step in DOS 2300-6, the surveillance was immediately repeated. Upon successful completion with no complications HPCI was declared operable.

ACTIONS TAKEN TO PREVENT RECURRENCE

1. The event has been reviewed with the personnel involved, regarding procedural adherence and the need for timely review of IST limitations.

2. DOS 2300-6 was revised to include specific requirements regarding timely review of IST limitations.

3. The event will be reviewed with station personnel in an upcoming tailgate session.

4. A thorough review of HPCI operating and surveillance procedures is also in progress. This review will include consideration of a separate surveillance for HPCI valve testing, consideration of incorporation of IST requirements into the HPCI pump testing surveillance and reviewing the prerequisites and action steps for consistency and format.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED FOR ALL ITEMS

Full compliance was achieved when HPCI was retested in accordance with DOS 2300-6 and declared operable at 0525 hours on April 5, 1988.

Action Items 1 and 2 have been completed.
Action Item 3 will be completed by July 7, 1988.
Action Item 4 will be completed by December 31, 1988.