



Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

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September 24, 1990

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

Subject: Dresden Station Units 2 and 3
Response to Notice of Violation
Contained in Inspection Report
50-237/90017 and 50-249/90017
NRC Docket Nos. 50-237 and 50-249

Reference: W. Shafer (NRC) letter to C. Reed (CECo),
dated August 24, 1990.

Mr. Davis:

The referenced letter transmitted Inspection Report 50-237/90017 and 50-249/90017 for Dresden Station. The Inspection Report contained one (1) Notice of Violation regarding inappropriate equipment outage checklists. Commonwealth Edison Company (CECo) has reviewed the Notice of Violation and agrees that the violation occurred as described. Attachment 'A' to this letter presents CECo's response to the violation, and describes corrective actions which are being taken to prevent similar occurrences.

Please direct any questions or comments on this response to this office.

Respectfully,

T. J. Kovach
Nuclear Licensing Manager

Attachment A: Commonwealth Edison Company Response to
Notice of Violation 50-237/90017-02.

cc: B. Siegel - NRR Project Manager
NRR Document Control Desk
S. DuPont - Senior Resident Inspector, Dresden

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ATTACHMENT A

COMMONWEALTH EDISON COMPANY
RESPONSE TO NOTICE OF VIOLATION
50-237/90017-02

VIOLATION (50-237/90017-02)

10 CFR 50, Appendix B, Criterion V, as implemented by Commonwealth Edison Company's Quality Assurance Program, requires that activities affecting quality be prescribed by documented instructions, procedures or drawings of a type appropriate to the circumstances.

Contrary to the above, documented instructions for activities affecting quality prescribed in equipment outage checklists were inappropriate to the circumstances in the following cases:

- a. Outage number III-460 implemented on February 4, 1990 failed to recognize all consequences of a fuse removal, resulting in an unexpected Group II primary containment isolation, standby gas treatment system automatic initiation and reactor building ventilation system isolation.
- b. Outage number II-412 implemented on June 11, 1990 prescribed the closure of incorrect valves, resulting in an unexpected recirculation pump trip.
- c. Outage number II-421 implemented on June 13, 1990 failed to recognize all consequences of opening a breaker, resulting in an unexpected half Group II primary containment isolation signal.

This is a Severity Level IV violation (Supplement I)

RESPONSE

Commonwealth Edison Company agrees with the violation as stated in the Notice of Violation. Although the three cases cited involved inappropriate equipment outage checklists for existing plant conditions, there is a fundamental difference between the recirculation pump trip event that occurred on June 11, 1990 and the other two cases cited. The February 4, 1990 and June 13, 1990 events resulted from inattention to detail during the preparation and review of the equipment outage checklists. In the recirculation pump trip event, the equipment outage checklist was prepared with a drawing which did not indicate a requested drawing change to reflect the in-plant labeling of the temperature control valves. Additionally, the operator hanging the outage failed to question activities that did not seem appropriate for the work in progress and plant conditions.

Dresden Station has been conducting plant walkdowns to upgrade plant labeling. Items which are found not to conform with common labeling convention are corrected and drawing changes submitted. In the recirculation pump trip event, the as-built drawing in the control room had been updated to reflect the correct labeling of the temperature control valves as identified during the plant walkdown; however, that drawing was not used in preparation of the equipment outage checklist.

As a result of these events, Dresden Station has taken actions to emphasize: 1) the need to contact appropriate supervisory personnel if questions or uncertainties arise during any plant activity; 2) the joint responsibility of Operating Department personnel and Maintenance Department work analysts to perform a thorough review to determine the impact of all equipment outages; and 3) the use of the most up-to-date information available when preparing and reviewing equipment outages.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

Immediate actions to restore the plant to normal conditions were:

1. February 4, 1990 event - The subject fuse was immediately replaced, the isolation reset, and the Standby Gas Treatment and Reactor Building Ventilation Systems were returned to normal.
2. June 11, 1990 event - The subject valves were reopened, but not in time to prevent the trip of the recirculation pump. Control room operators correctly carried out the requirements of DOA 202-1, "Recirculation Pump Trip - One or Both Pumps." The plant was returned to two loop operation.
3. June 13, 1990 event - The subject breaker was racked back in, and the half Group II isolation signal was reset.

Immediately following each event, an investigation was conducted to determine the root cause of each event, and to formulate and implement corrective actions. The events in June 1990 prompted additional corrective actions regarding the development, review and implementation of equipment outages.

CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER NON-COMPLIANCES

Following the June 1990 events, the following corrective actions were taken.

1. Operations Department Memorandum #18 was issued to reaffirm with all Operations Department shift personnel the need to use the most up-to-date available critical drawings when preparing and verifying equipment outages, and to contact supervisory personnel when activities do not seem appropriate for current plant conditions/evolutions prior to performing the activity.
2. A letter discussing the causes of the three events, the similarities of the events, and the corrective actions taken to prevent reoccurrence has been sent to all Operating Department shift personnel and Maintenance Department work analysts. A further detailed review of these events with shift personnel and work analysts will be conducted by December 14, 1990.

3. In order to provide readily available, accurate information for personnel involved with equipment outage preparation and verification, an additional set of as-built critical drawings will be placed in the Operations Department Scheduler's office. Dresden Administrative Procedure 2-9, "As-Built Critical Drawings," is being revised to control these drawings. This set of drawings will be copies of those used in the control room and will reflect the "as-built" condition of the plant, including any outstanding drawing change requests. These actions will be completed by September 28, 1990.
4. Dresden Station has formed a committee to develop a "Self-Check" policy for personnel to follow while performing work in the plant. The policy includes verifying all equipment, labeling and procedures prior to starting a job, anticipating expected plant responses, stopping if any response is not received, and observing that all anticipated responses occur. A draft of these guidelines has been developed and will be implemented by October 1, 1990.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on June 13, 1990 when the half Group II isolation was reset.