APPENDIX

NOTICE OF VIOLATION

As a result of the inspection conducted on September 24 through November 16, 1990, and in accordance with the "General Policy and Procedures for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1990), the following violations were identified:

1. 10 CFR 50, Appendix B, Criterion II, as implemented by Commonwealth Edison's "Quality Assurance Program" requires indoctrination and training of personnel performing activities affecting quality as necessary to assure that suitable proficiency is achieved and maintained.

Contrary to the above, indoctrination and training of personnel performing activities affecting quality was inadequate in assuring proficiency was achieved and maintained as to administrative requirements as indicated in the following examples:

- a. Lack of operations personnel knowledge of Dresden Administrative Procedure (DAP) 7-5, "Operating Logs and Records," Revision 8, and Dresden Operating Abnormal (DOA) Procedure 902-5 G-2, Revision 3, requirements for maintaining the Control Rod Drive Accumulator High Water / Low Pressure Alarm Log (AHWLPAL) resulted in the AHWLPALs for both units not being maintained between April 1990 and August 3, 1990. As such the licensee's program to identify repeat failures of accumulator alarms was not effective during that time period. (50-237/90023-01a (DRP))
- b. Lack of technical staff personnel knowledge regarding recognizing and processing conditions adverse to quality resulted in a failure to properly identify a procedural nonadherence involving maintenance of the AWHLPAL when discovered in May 1990. Because of this, corrective actions to prevent recurrence were not taken at that time. (50-237/90023-01b (DRP))

This is a Severity Level IV violation (Supplement 1).

2. 10 CFR 50, Appendix B, Criterion V, as implemented by Commonwealth Edison Company's Quality Assurance Program, requires that activities affecting quality be accomplished in accordance with documented instructions, procedures or drawings.

Contrary to the above, activities affecting quality were not accomplished in accordance with documented instructions, procedures, or drawings in the following examples:

a. Dresden Operating Procedure (DOP) 1900-3, "Reactor Cavity-Dryer Separator Storage Pit Fill and Operation of the Fuel Pool Cooling and Cleanup System During Refueling," Revision 8, requires constant communication between the refueling floor and the control room while filling the reactor vessel. Constant communication between the refueling floor and the control room was not maintained while

9012130320 901207 PDR ADOCK 05000237 0 PDC filling the Unit 2 reactor vessel on October 14, 1990, resulting in the overfilling of the vessel into the ventilation ducts and contamination of various areas of the third and fourth floors of the reactor building. (50-237/90023-02a (DRP))

- b. Specific practices required by DAP 3-5, "Out of Service and Personnel Protection Cards, Revision 22, were not followed as to preparation, review, approval, documentation and independent verification in the removal and return to service of the Unit 2 diesel fuel oil day tank drain valve on October 29, 1990. This resulted in the inadvertent draining of the day tank when the drain valve was placed in the incorrect position. (50-237/90023-02b (DRP))
- c. DAP 7-14, "Control and Criteria For Locked Equipment and Valves," Revision 2, requires manual valves in the flowpath of systems required for plant shutdown during post-accident situations or which provide a controlled path to the environs, including primary and secondary containment isolation valves to be locked. Prior to November 1990, manual valves including the Units 2, 3 and 2/3 diesel generator service water three-way valves and the Units 2 and 3 drywell manifold sampling system containment isolation valves were not locked or designated to be locked. (50-237/90023-02c (DRP))
- d. DAP 15-6, "Preparation and Control of Work Requests," Revision 0, requires work to be performed per repair manual(s), travelers/procedures, or work instructions provided in the work package. On October 15, 1990, work prescribed for disassembly of the Outboard Containment Isolation Feedwater Check Valve 220-62B was performed instead on Outboard Containment Isolation Feedwater Check Valve 220-62A. (50-237/90023-02d (DRP))
- e. DAP 15-6, "Preparation and Control of Work Requests," Revision 0, requirements were violated on August 8, 1990, when work prescribed for calibration of Unit 3 Torus to Reactor Building Vacuum Breaker A Pressure Transmitter DPT-1622A was performed instead on Pressure Transmitter DPT-1622B. This resulted in advertant opening of the Unit 3 Reactor Building Vacuum Breaker B. (50-237/90023-02e (DRP))

This is a Severity Level IV violation (Supplement 1).

3. 10 CFR 50, Appendix B, Criterion XVI, as implemented by Commonwealth Edison's "Quality Assurance Program," requires that conditions adverse to quality be promptly identified and corrected and, in the case of significant conditions, the measures assure the cause is determined and corrective action taken to prevent repetition.

Contrary to the above, following the fuel bundle mispositioning events of January 10 and 12, 1989, corrective actions were insufficient to prevent repetition in that similar events occurred on October 1, 1990 and October 2, 1990. (50-237/90023-08 (DRP))

This is a Severity Level IV violation (Supplement 1).

Pursuant to the provisions of 10 CFR 2.201, you are required to submit to this office within thirty days of the date of this Notice a written statement or explanation in reply, including for each violation: (1) corrective action taken and the results achieved; (2) corrective action to be taken to avoid further violations; and (3) the date when full compliance will be achieved. Consideration may be given to extending your response time for good cause shown.

12/07/90

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