



Commonwealth Edison
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October 25, 1989

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

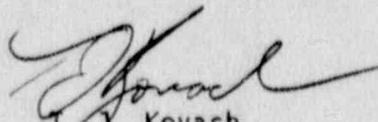
Subject: Braidwood Station Units 1 & 2
Response to Inspection Report Nos.
50-456/88-022 and 50-457/88-022,
NRC Docket Nos. 50-456 and 50-457

Reference: (a) E. G. Greenman letter to C. Reed dated
September 25, 1989

Dear Mr. Davis:

Reference (a) provided the results of the inspection conducted by Messrs. T. M. Tongue, T. E. Taylor, G. A. VanSickle, W. J. Kropp, and Ms. D. Calhoun on July 30 through September 16, 1989 of activities at Braidwood Station. Reference (a) indicated that certain activities appeared to be in violation of NRC requirements and that a response is required. Also, Reference (a) requested that Commonwealth Edison provide a description of the management actions to assure proper and timely Emergency Notification System notifications in the future. These actions are included in Enclosure 1. The Commonwealth Edison Company response to the Notice of Violation is provided in Enclosure 2.

If you have any questions regarding this response, please direct them to this office.


T. J. Kovach
Nuclear Licensing Manager

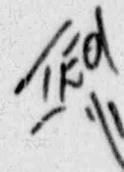
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Enclosures

cc: NRC Resident Inspector - Braidwood
NRC Document Control Desk

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ENCLOSURE 1

COMMONWEALTH EDISON COMPANY RESPONSE TO

INSPECTION REPORT NOS. 456/89022 and 457/89022

Commonwealth Edison's Braidwood Station has been cited for failure to make an appropriate Emergency Notification Systems (ENS) notification four times in the previous two years. In response to each incident, Braidwood Station has taken corrective action to prevent recurrence of a similar violation. The incidents and corrective actions taken are as follows.

Two violations involved the failure of station personnel to declare an unusual event when a power reduction required by Technical Specifications was initiated. The failure to declare the emergency classification was due to unclear Emergency Action Levels (EALs) and faulty interpretation of these EALs by station personnel. Commonwealth Edison's Corporate Emergency Planning has since revised and issued generic EALs with additional reporting guidance. Training was provided to all licensed personnel on these revised EALs and events. This training and guidance from Commonwealth Edison's Corporate Emergency Planning was also provided to appropriate station management.

The remaining two violations were due to the failure of plant personnel to recognize that failures of specific components constituted a reporting requirement as specified in Braidwood Administrative Procedure (BwAP) 1250-6, "Reportable/Potentially Significant Event Screening and Notification." As a result of the first of these events, the examples which were cited in the attachments of BwAP 1250-6 listing requirements by time and category, were incorporated into the body of the procedure. In addition, a contributing cause of this event was the failure of personnel to make the ENS notification because complete information regarding plant conditions was not available when the time limit for notification expired. Guidance was added to BwAP 1250-6 directing that ENS notifications be made in a timely manner to provide the NRC with information currently available. Supplementary calls could then be placed later as necessary to update the NRC as required.

During the second and most recent event, shift personnel did not consult BwAP 1250-6 because they did not deem the failure of a given component to meet the threshold for ENS screening. Corrective actions for this event will include providing shift personnel with a prominently posted list of components, the failure of which directly meets a reporting requirement. This posting will make readily available to control room personnel the reporting requirement for these components. In addition to this posting BwAP 1250-2, "Deviation Reporting" will be revised to include a checklist to aid in the identification of appendant issues, such as ENS notification considerations.

The corrective actions taken by Braidwood Station as a result of the above violations have been successful in preventing violations with similar root causes. Braidwood Station believes that the most recent corrective actions, as well as heightened awareness of ENS requirements on the part of station personnel will ensure satisfactory performance in this area in the future.

ENCLOSURE 2

COMMONWEALTH EDISON COMPANY

RESPONSE TO INSPECTION REPORT

456/89022 and 457/89022

VIOLATION:

10 CFR 50.72, paragraph (b)(1)(ii), requires a licensee to notify the NRC via the Emergency Notification System within one hour for "Any event or condition during operation that results in the condition of the nuclear power plant, including its principal safety barriers, being seriously degraded ..."

Contrary to the above, on September 2, 1989, at 1:00 a.m., during testing of main steam safety valve IMS017C, the safety stuck open. Although an effort was made to close the valve, it remained opened at various positions for approximately 42 minutes, resulting in a 5 degrees fahrenheit reduction in reactor coolant temperature. This condition is considered to be a degradation of a principal safety barrier. The ENS notification was made at 7:55 a.m., about six hours late.

RESPONSE:

Commonwealth Edison acknowledges that Braidwood Station failed to make a timely Emergency Notification System (ENS) notification in accordance with Braidwood Administrative Procedure (BwAP) 1250-6 "Reportable/Potentially Significant Event Screening and Notification." However, events leading to this failure to notify were unique. Commonwealth Edison would like to present the circumstances that led to the occurrence of this event.

On September 1, 1989 a controlled power decrease in preparation for a refuel outage was in progress on Unit 1. Testing of the Main Steam Safety Valve lift setpoints was in progress.

At 2340, the initial lift test of safety valve IMS017C was performed. The valve lifted at 1158 psig, which was 5.25 psig less than the acceptance criteria. The Shift Engineer (SE) and Shift Control Room Engineer (SCRE) were notified and IMS017C was declared inoperable. The actions required by Technical Specifications were complied with. During these test lifts, the turbine was taken offline as part of the normal power decrease.

During the next 1 hour and 20 minutes, 3 additional test lifts of the safety valve were attempted. All lift setpoints were outside the acceptance criteria. On the fourth lift at 0100, on September 2, 1989, IMS017C did not reset.

At approximately 0115 an additional lift was performed in an attempt to clear any possible obstructions and reseat the valve. This was not successful and steam flow through the valve increased. At 0135, as a precautionary measure, the Braidwood Chemistry Department was requested to sample the 1C Main Steamline to aid in determining the status of any potential offsite release. At 0142 1MS017C reseated as Main Steamline pressure decreased to 1030 psig. Stable plant conditions were immediately established.

The initial evaluation on the stuck open safety valve performed by the SE and SCRE resulted in the following conclusions:

1. The safety valve reseated within time constraints of the appropriate containment isolation valve Technical Specification and as such did not constitute a failure of a containment isolation valve function.
2. The failure to reseat should be documented as a deviation.

BwAP 1250-6 was not consulted as the Steam Generator Safety Valve did not lift to relieve an actual overpressure condition. The safety valve was opened using a test procedure.

At approximately 0700, during operating shift turnover, this event was discussed with the oncoming shift crew. In response to a general suggestion, BwAP 1250-6 was consulted and reporting requirements identified. The appropriate ENS notification was made at 0755 on September 2, 1989 pursuant to 10CFR50.72(b)(1)(ii).

This event had no effect on the safety of the plant or the public. The event resulted in a small decrease in Main Steamline Pressure with minimum RCS temperature for criticality always maintained. There was no detectable radioactivity in the main steam system and therefore, no release to the environment.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED:

Following identification of the reporting requirement, the ENS notification was made on September 2, 1989 at 0755. This fulfilled the reporting requirement.

CORRECTIVE ACTION TAKEN TO AVOID FURTHER VIOLATION:

The personnel involved in this event were included and participated in a Braidwood Station Error Evaluation Presentation in order to identify the root and contributing cause of the event. Based on the conclusions of this presentation, the following corrective actions are being initiated to prevent recurrence:

1. A specific list of components will be developed which, if failed, requires consideration for ENS notification per BwAP 1250-6. This list will be posted in an appropriate location so as to be readily available to the control room supervisor.

2. The reporting requirements for these components will be included in licensed operator requalification training.
3. The above information will be developed in the form of an Operator Aid. In addition to the specific components, this Operator Aid will list examples of 1 hour and 4 hour reporting requirements.
4. Braidwood Administrative Procedure 1250-2, "Deviation Reporting" will be revised to include a checklist to aid in the identification of appendant issues, such as ENS notification considerations.

DATE OF FULL COMPLIANCE:

The actions listed above are expected to be completed by December 31, 1989.