

December 29, 1982

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

Subject: Zion Station Units 1 and 2

Response to IE Inspection Report 50-295/82-20 and 50-304/82-18 NRC Docket Nos. 50-295/304

Reference (a): December 3, 1982 letter from C. E. Norelius to Cordell Reed

Dear Mr. Keppler:

Reference (a) provided the results of an inspection conducted by Messrs. R. Farrell, R. Hasse, and J. Peschel of your office on October 25-29, 1982, of activities at Zion Station. During that inspection, certain activities appeared to be in noncompliance with NRC requirements. The Attachment to this letter contains Commonwealth Edison's response to the Notice of Violation.

In reviewing the circumstances surrounding these violations, it has been determined that item (2) should not be considered an item of noncompliance. The information supporting this conclusion is presented in the Attachment to this letter. Accordingly, it is respectfully requested that Violation (2) be withdrawn.

To the best of my knowledge and belief, the statements contained herein and in the attachment are true and correct. In some respects these statements are not based on my personal krowledge 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.

Very truly yours,

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CW Schroeder 12/29/82 L. O. DelGeorge Director of Nuclear Licensing

Attachment 5675N

Response of Notice of Violation

Item of Noncompliance (1)

10 CFR 50, Appendix B Criterion V states in part:
"Activities affecting quality shall be prescribed by
documented instructions, procedures . . . and shall be
accomplished in accordance with these instructions,
procedures, or drawings."

The Commonwealth Edison Company Topical Report, CE-1-A, Revision 22, Section 5, states in part: "Activities affecting quality are required by the Edison quality program to be prescribed by documented instructions, procedures . . "

Contrary to the above, the following instances were identified in which activities were not conducted in accordance with procedures:

- a. Procedure TI-202 requires that Form TI-102-21 be used to track the progress of licensed operators through the accelerated requalification program. Of the four training records reviewed, two instances were identified in which the form was not used to track the operator's progress and two instances where the form did not reflect the current status of the operator's training.
- b. Procedures ZAP 2-52-1 and TI-502 require that an introduction to quality assurance be included in the Nuclear General Employee Training Lecture. The lecture presented on October 26, 1982 did not address quality assurance.
- c. Procedure PT-11 requires that out-of-tolerance diesel generator parameters be recorded on the front page of the procedure along with any corrective action taken. Three instances were identified where out-of-tolerance parameters were not recorded as required and there is no record of any corrective action having been taken.
- d. Procedure TSS 15.6.20V requires that valve stroke times be recorded and compared to required stroke times. One instance was identified in which stroke times for two valves were not recorded and no action was taken for a third valve that exhibited an out-of-tolerance stroke time.

Corrective Action Taken and Results Achieved

- a. License requalification training is conducted in accordance with Procedure TI-202. Form TI-102-21 was developed to provide a convenient form for documenting compliance with the required program. Compliance with the required program was verified for the individuals whose training records did not contain properly completed form TI-102-21 by reviewing the primary items of documentation in their training records (attendance records, examinations, etc.)
- b. On the date in question, the instructor overlooked the last page of the lesson plan, which addresses quality assurance. This is considered an isolated case of individual oversight. Instructors have been cautioned to ensure that all required material is presented in accordance with the lesson plans.
- c. Procedure PT-11 defines acceptable diesel generator performance by listing acceptable values for certain key parameters. For the instances cited, it was verified that these parameters were within their acceptable values.

PI-11 further states:

"The remaining readings on the data sheets indicate expected nominal operating values. They are used to trend engine performance and not as an indication of engine operability".

The results of the tests cited have been reviewed by the Technical Staff engineer responsible for performance trending and have been considered in his recommendations for preventive and corrective maintenance.

d. Stroke times for valves RH8716C and RH9000 were not recorded in April 1981 because the valves could not be stroked, due to the fact that the Unit was in the cold shutdown condition with the RHR system operating. Stroke times obtained following the Unit's return to power were verified to be acceptable.

Procedure TSS 15.6.20V is designed to implement the valve testing recommendations of the ASME Code.

Although Zion's Inservice Testing Program has not yet been reviewed and approved by the NRC, Zion has been following this program and trending valve performance. A review of the performance of valve VC8106 revealed

acceptable stroke times at the test before and the test after the April, 1981, test. Therefore, no corrective maintenance was deemed necessary.

Corrective Action to be Taken to Avoid Further Noncompliance

- a. Procedure TI-202 will be revised to make the use of Form TI-102-21 optional. Documentation of compliance with the required training program will continue to be provided by the material contained in each individual's training record.
- b. It is intended to record the Nuclear General Employee Training Lectures and other similar material on video tape. This will eliminate the possibility of an instructor overlooking a part of the lesson plan.

c. The need for accurate data entry, as well as general procedure adherence, will be discussed with all shift personnel at the weekly shift meetings.

d. This item will be 'cluded in the discussions regarding item (c) above.

Date of Full Compliance

- a. Full compliance has been achieved. The procedure change revising the use of Form TI-102-21 will be completed by February 1, 1983.
- b. Full compliance has been achieved.
- c. Full compliance has been achieved. Discussions at the weekly shift meetings will be completed by January 14, 1983.
- d. Full compliance has been achieved. This item will be included in the discussions regarding item (c) above.

Item of Non-Compliance (2)

Zion Technical Specification 6.6.2.b states in part:
"The reportable occurrences discussed below shall be the subject of written reports to the Director of the appropriate Regional office within 30 days of occurrence of the event." Specification 6.6.2.b(3) further identifies the following event as reportable: "observed inadequacies in the implementation of administrative or procedural controls which threaten to cause reduction of degree of redundancy provided in reactor protection systems or engineered safety feature systems."

Contrary to the above, pilot cell voltages for several station batteries were not measured or recorded between March 22 and April 25, 1982 as required by Technical Specification 4.15.1.0.E.l. This was the result of an inadequate procedure (later corrected) and the event was not reported as required.

Discussion

Commonwealth Edison has determined that this item should not be considered an item of noncompliance. This conclusion is based on the conclusion contained in Regulatory Guide 1.16, "Reporting of Operating Information-Appendix A Technical Specifications", which provides the basis for the reporting requirements contained in Zion Technical Specification 6.6.2.

R.G. 1.16, Section 2.b(3), lists the following as an item which requires a thirty day report:

Observed inadequacies in the implementation of administrative or procedural controls which threaten to cause reduction of degree of redundancy provided in reactor protection systems or engineered safety feature systems. The following are examples:

- a. One of the three diesel generators tripped from high temperature because cooling water valves were lined up incorrectly.
- b. Isolation valve for a low-pressure trip switch was found closed with system pressure locked in. Trip of switch would not occur at low pressure. Improper return to operation following maintenance was the cause.
- c. Failure to perform surveillance tests at the required frequency.

Implicit in the list of examples is the idea that the event must cause an actual reduction in the degree of redundancy provided (examples a and b) or must result in a lack of assurance of the operational status of a system (example c).

At Zion, a daily surveillance is performed on the batteries in accordance with procedure PT-O Appendix K. The battery voltage and DC Bus grounds are recorded. Once each week, in addition to the daily readings, pilot cell data are recorded. This includes voltage, specific gravity, temperature, and level. In view of the extensive surveillance performed on the batteries, the omission of the single item of weekly pilot cell voltage readings does not cause a reduction in the degree of redundancy or cast doubt as to the operational readiness of the batteries. Therefore, this item is not reportable under the provisions of Technical Specification 6.6.2(b).