DCD/DCB (RIDS)

January 30, 1991

Docket No. 50-456
License No. NPF-72
EA 90-208

Commonwealth Edison Company
ATTN: Cordell Reed
Senior Vice President
Opus West III
1400 Opus Place
Downers Grove, Illinois 60515

Gentlemen:

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY - $87,500 (NRC INSPECTION REPORT NO. 50-456/90023 AND AUGMENTED INSPECTION TEAM REPORT NO. 50-456/90020)

This refers to the NRC Augmented Inspection Team (AIT) review conducted on October 4-6, 1990 and special followup inspection conducted on November 19-23, 1990 of events that led to a loss of reactor coolant and personnel contamination on October 4, 1990 at the Braidwood Nuclear Power Station, Unit 1. The reports documenting these inspections were sent to you by letters dated October 23, 1990 and December 3, 1990, respectively. During these inspections, violations of NRC requirements were identified. An Enforcement Conference was held on December 11, 1990 at the Braidwood facility to discuss the violations, their cause, and your corrective actions. The report summarizing this conference was sent to you by letter dated December 19, 1990.

The violations involved the failure of the control room operations staff (licensed operators and senior operators) and Technical Staff Engineers (TSE) to adhere to various administrative and surveillance procedures during the performance of multiple Residual Heat Removal (RH) system tests on October 4, 1990. The most significant aspect of this event was the failure of the licensed operators to maintain positive control over plant evolutions and system configuration. Contributing programmatic deficiencies included (1) coordination problems between the Work Planning Department, the Operations Department and the Technical staff, including poor intra and inter-shift communications, (2) weaknesses in the shift turnover process regarding in-progress testing, (3) the lack of rigorous guidance for controlling multiple surveillance evolutions and (4) excessive overtime for personnel performing complex safety-related work. Senior plant management appears to have failed to ensure that management expectations regarding control of plant evolutions were appropriately implemented, particularly those that are infrequent or unusual.

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

IE14

A March 18, 1990 Unit 2 loss of reactor coolant event highlighted problems with control room communications and system configuration control for abnormal lineups during plant shutdown conditions. Your "Heightened Level of Awareness" special operating order (HLA) developed in response to this event was viewed as a good start toward correcting those deficiencies. Though the shift preceding the October event implemented the HLA, the following shift did not. Senior plant management failed to ensure that corrective actions and expectations associated with the March event were effectively communicated and implemented. Had this program been rigorously followed, this event may not have happened.

Fatigue appears to have contributed to the October event because the technical staff engineers involved had worked excessive hours (18 to 20 hours). Though provisions were in place to have a relief crew available, there were no controls in place to require management approval prior to cancelling the relief crew work assignment. The engineers involved had a major responsibility to ensure that surveillance activities are conducted in a manner to minimize unnecessary challenges to the plant. The reduction in awareness demonstrated by the engineers may have been due to excessive work hours.

While the out of sequence performance of a surveillance test step initiated the event, the root cause was a significant failure in the control room command and control function. The violations represent a recurring breakdown in the control of licensed activities and a significant lack of attention toward licensed responsibilities. It is clearly not acceptable for the control room to not be cognizant of significant plant activities. Therefore, in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C (1990), the violations related to the control of operations have been classified in the aggregate at a Severity Level III. The violation related to inadequate overtime controls for the technical staff engineer has been classified at a Severity Level IV.

Following the October event, you instituted a number of additional corrective actions that included development of a program to review operational performance through periodic audits, crew evaluations and performance feedback. Various procedures were clarified and senior management met with each shift crew to emphasize their responsibilities and authorities. Additionally, guidance has been provided for Technical Staff performed surveillances and overtime and the Operation Shift Advisor has been assigned to assist the SCRE in supervising surveillance activities.

To emphasize the need for management control and oversight of safety-related activities regarding surveillance testing and the conduct of operations, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the amount of $87,500 for the Severity Level III problem. The base value of a civil penalty for a Severity Level III violation or problem is $50,000. The escalation and mitigation factors in the Enforcement Policy were considered.

The base civil penalty was mitigated by 25% for identification and reporting. However, the full amount allowed under the Policy was not applied because of the self-disclosing nature of this event. The base civil penalty was neither escalated nor mitigated because your corrective actions did not adequately address the long term resolution of management overview of plant activities.

In this regard the NRC takes specific exception to the views expressed in your Confirmatory Action Letter response of November 5, 1990, that the "reduction of awareness that occurred during the event is believed to be unique to the individuals involved and does not represent a normal characteristic..." or that "the deficiencies that led to the March 18 event were not evident in this case...and our investigation concluded that a loss of command and control did not occur." The cover letter transmitting Inspection Report No. 50-457/90012, dated April 18, 1990, noted the deficiency in communication practices between supervisors and operators during non-routine evolutions such as occurred on March 18, 1990. That event was similar to the October event with regard to how licensed responsibilities were discharged in the control room during non-routine evolutions. Had adequate corrective action been implemented for that event, this current problem likely would not have occurred. Therefore, as a result of such poor past performance, the base civil penalty is being escalated by 100%. The other factors were considered and no further adjustment of the civil penalty was deemed appropriate. Therefore, a $87,500 civil penalty is assessed for these violations.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. In light of another enforcement action pending against your Quad Cities facility (EA 90-203) involving plant operations where management did not assure sufficient oversight and training, you should discuss how you intend to apply the corrective actions adopted for the Braidwood incident to your other licensed facilities. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,
Original Signed by
A. Bert Davis

A. Bert Davis
Regional Administrator

Enclosure: Notice of Violation and
Proposed Imposition of Civil Penalty

See Attached Distribution

RIII	RIII	OE:D	DEDR	RIII	RIII
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Pederson/db	Miller	JLieberman	JSniezek	Paperiello	Davis
01/28/91	01/28/91	01/25/91	01/25/91	01/29/91	01/29/91

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