



Commonwealth Edison

One First National Plaza, Chicago, Illinois

Address Reply to: Post Office Box 767

Chicago, Illinois 60690

September 22, 1983

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

Subject: Dresden Station Units 1, 2, and 3
Response to Inspection Report Nos.
50-010/83-09, 50-237/83-14 & 50-249/83-13
NRC Docket Nos. 50-010, 50-237, and 50-249

Reference (a): C. E. Norelius letter to Cordell Reed
dated August 23, 1983.

Dear Mr. Keppler:

This letter is in response to the inspection conducted by Messrs. T. M. Tongue and S. Stasek during the period of May 2 through July 19, 1983, of activities at Dresden Station. Reference (a) indicated that certain activities appeared to be in noncompliance with NRC requirements. The Commonwealth Edison Company response to the Notice of Violation is provided in the enclosure.

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 upon my personal knowledge 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.

If you have any further questions on this matter, please direct them to this office.

Very truly yours,

B. Farrar
for D. L. Farrar
Director of Nuclear Licensing

BR/lm

Attachment

cc: NRC Resident Inspector - Dresden

7350N

8310140049 831011
PDR ADOCK 05000010
Q PDR

SEP 26 1983

COMMONWEALTH EDISON COMPANY

ATTACHMENT A

RESPONSE TO NOTICE OF VIOLATION

The items of noncompliance identified in the Appendix of the letter dated August 23, 1983, are responded to in the following paragraphs:

1. 10 CFR, Appendix B, Criterion II, "Quality Assurance Program", requires that activities affecting quality shall be conducted under suitably controlled environmental conditions. Commonwealth Edison Company Topical Report CE-1-A, "Quality Assurance Program for Nuclear Generating Stations", Section 2.2, commits to comply with Regulatory Guide 1.39 (1973), "Housekeeping Requirements for Water-Cooled Nuclear Power Plants", to implement those requirements of 10 CFR 50, Appendix B, Criterion II, Regulatory Guide 1.39 (1973), Section C, endorses the requirements and recommendations of ANSI N45.2.3-1973, "Housekeeping During the Construction Phase of Nuclear Power Plants". ANSI N45.2.3-1973, Section 3.5, requires that periodic examinations of areas be conducted to ensure adequate of housekeeping practices including protection of installed items from factors which may result in damage to those items.

Contrary to the above, adequate protection from dust, moisture and water spray from nearby components was not provided to safety related breaker panels for the emergency diesel generators, low pressure coolant injection pumps and core spray pumps for Units 2 and 3. On June 22, 1983, the inspector observed the upper panel doors open on breaker panels 23-1, 24-1, 33-1, and 34-1. This condition existed for at least three shifts. In addition, the cover doors on the Unit 2 24/48 volt battery chargers were discovered open by the inspector on June 24, 1983.

Corrective Action Taken and Results Achieved

Immediately after the discovery of the open cabinet doors on June 23, 1983, Operations personnel closed and latched all of the affected cabinets. In addition, the Unit 2 24/48 volt battery charger cabinet doors were immediately closed. The importance of assuring the cabinet doors are closed and latched was also emphasized to shift personnel via daily orders.

Corrective Action Taken to Avoid Further Noncompliance

Discussions were conducted with shift supervision following the event. It was concluded that the doors were opened as the result of the daily surveillance (DOS 040-5) routinely conducted on Shift 1. The control power fuses in the Unit 2 and Unit 3 Emergency Bus Cabinets are required to be visually checked.

Subsequent to this event, an Operations Memo has been issued to all Operations Supervision to further emphasize the seriousness of open emergency bus breaker doors.

In addition, a memo will be issued to all departments at Dresden to assure the adequacy of housekeeping practices include protection of installed items from factors which may result in damage to those items such as open breaker cabinet doors or open junction boxes.

Date of Full Compliance

The Operations Memo has been issued and the departmental memo will be issued by October 31, 1983.

2. 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions", requires that measures be established to ensure that identified condition adverse to quality be corrected. Commonwealth Edison Company Topical Report CE-1-A, "Quality Assurance Program for Nuclear Generating Stations", Sections 16, states that corrective actions are verified for satisfactory completion to preclude repetition.

Contrary to the above, identified corrective actions following an event on May 2, 1983, involving an inoperable core spray injection valve on Unit 3 (Licensee Event Report No. 50-249/83-18) were not implemented resulting in the inoperability of a Unit 2 core spray injection valve on June 3, 1983 (Licensee Event Report 50-237/83-45).

Corrective Action Taken and Results Achieved

Upon discovery that the breaker setting for Valve 2-1402-25B had not been changed, Electrical Maintenance was immediated reinstructed to increase the setting. This was completed on June 8, 1983. There have been no further failures of this valve since the breaker setting was increased.

Corrective Action Taken to Avoid Further Noncompliance

An investigation of this event revealed two major factors which directly or indirectly caused this event. The first factor was the use of a motor operator data sheet which was not controlled by a station procedure. The second factor was personnel error in that the maintenance personnel were not aware of the work as corrective action for a previous valve failure and therefore because parts were not available to complete the entire job, an error in judgment was made in that all of the work was placed on hold awaiting parts. A breaker trip change and thermal overlook replacement were both required by the work request.

The Unit 3 1402-25A and B and Unit 2 1402-25A Valves breaker trip settings had been increased prior to June 8, 1983 event.

Subsequent to these events, DMP 040-6 has been extensively revised to incorporate and update the use of the motor operated valve data sheet. This revision has been issued.

In order to prevent the personnel error in the future, three corrective measures have been taken. The first action was to instruct Operating Engineers to more clearly delineate Technical Specification requirements on work requests.

The second corrective action was immediate discussions with the personnel involved with the event which stressed the importance of in-depth investigation and prompt corrective actions to resolve the problems with safety related equipment. In addition, a memo was issued to all Maintenance Department Heads to stress the importance of the above actions.

Finally, distribution of handwritten copies of all CECo Deviation Reports, regarding of reportability, is being made to all Maintenance Departments so that the reasons a particular work request must be given prompt attention are more clearly understood by maintenance management.

Date of Full Compliance

The corrective actions described above have been implemented, and we believe full compliance has been achieved.

7350N