Commonwealth Edison
1400 Opus Place
Downers Grove, Illinois 60515

March 1, 1993

U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

Attention: Document Control Desk

Subject: Quad Cities Nuclear Power Station Units 1 and 2
Response to Notice of Violation
Inspection Report Nos. 50-254/92028; 50-265/92028
NRC Docket Numbers 50-254 and 50-265

Reference: E. Greenman letter to L. DelGeorge
dated January 29, 1993
transmitting NRC Inspection Report
50-254/92028;50-265/92028

Enclosed is Commonwealth Edison Company's (CECo) response to the Notice of Violation (NOV) which was transmitted with the referenced letter and Inspection Report. The NOV cited two Severity Level IV violations requiring a written response. As requested in the referenced letter, included is CECo's planned actions to ensure that adequate control is addressed for balance of plant activities. CECo's response is provided in the attachment.

If your staff has any questions or comments concerning this letter, please refer them to. Marcia Jackson, Compliance Engineer at (708) 663-7287.

Sincerely,

D. Farrar
Nuclear Regulatory Services Manager

Attachment

cc: A. Bert Davis, NRC Regional Administrator - RIII
C. Patel, Project Manager - NRR
T. Taylor, Senior Resident Inspector

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RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
50-254/92028; 50-265/92028

VIOLATION: 254(265)/92028-01

10 CFR Part 50, Appendix B, Criteria XVI requires, in part, that measures be established to ensure that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above, on November 25, 1992, a condition adverse to quality was not promptly corrected. Specifically, the licensee failed to complete corrective actions for a Notice of Violation issued on September 15, 1988, which involved a failure to take prompt corrective action to resolve a 1/2 diesel generator logic concern.

This is a Severity Level IV violation (Supplement 1)

REASON FOR THE VIOLATION

CECo acknowledges the violation which resulted from management oversight, personnel transition, and priority work load. Responsibility for this item has changed several times in the interim of developing the corrective actions. This, coupled with offsite personnel involvement, outage work, and multiple modification installations caused this item to be prioritized erroneously low.

For the Notice of Violation issued on September 15, 1988, the corrective actions were made in the form of procedural enhancements. These enhancements were done to prevent inadvertent tripping of the Diesel Generator on Underexcitation. These procedures addressed two individual scenarios. The first was implemented in June, 1988, and included steps to manually insert an Auto-Start signal when for some reason the DG failed to start or had tripped off line and conditions are such that emergency operation is required. The other condition of concern, made effective in March, 1990, cautioned operators on starting large loads while the engine is running in a loaded condition.

The proposed modification to the logic was being tracked on NTS as a corrective action to LER 254-86-032. This item did not have an assigned due date associated with it according to the NTS procedure in effect at the time. This contributed to the failure to identify the untimeliness of the implementation of the corrective action.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

The logic circuitry modification identified in CECo response to Notice of Violation dated October 17, 1988 was reevaluated and determined not to be a cost effective action to prevent recurrence. A supplemental report to the original Licensee Event Report (LER) was filed on January 27, 1993.

Station Policy, QCPP 0101, Issues Management, was implemented on November 12, 1992. This policy requires the assignment of an accountability date for all action items. The policy also requires supervisory review of all accountability date extension, thereby improving management overview of progress toward completion of required actions.

CORRECTIVE ACTIONS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

No additional corrective actions are necessary.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on January 27, 1993, when a supplemental report to the original Licensee Event Report, LER 254-86-032 was filed.

RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
50-254/92028; 50-265/92028

VIOLATION: 254(265)/92028-02

10CFR Part 50, Appendix B, Criteria V states, in part, that activities affecting quality shall be prescribed by documented instructions of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions.

Contrary to the above, on December 14, 1992, an instrument mechanic installed a temporary alteration on a reactor vessel level transmitter without documented instructions authorizing the activity.

This is a Severity Level IV violation (Supplement I)

REASON FOR VIOLATION

CECo acknowledges the violation which resulted from a personnel error by an Instrument Maintenance technician during calibration of a reactor water level transmitter. The technician reinstalled a tygon tube assembly, used for local reactor water level indication during refuel outages, without appropriate documentation and then failed to notify Instrument Maintenance management of its installation.

CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED

The tygon tube was valved out and the "A" NR GEMAC and NR Yarway level indication returned to a level comparable to the "B" instrumentation. The tygon tube assembly was subsequently removed by Instrument Maintenance (IM) per work request Q95394.

IM management held discussions with the Instrument Maintenance technician involved concerning performance expectations related to this event. These discussions stressed the need to ensure that the appropriate documentation is in place prior to performance of plant alterations. Additionally, emphasis was placed on the importance of prompt communications to supervisory personnel of actions taken when in question.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

This temporary alteration program, its application and control, was reviewed with all Instrument Maintenance personnel during a weekly tailgate meeting stressing the importance of plant configuration control. Additionally, a discussion concerning this event with all departments at the station will include the importance of communicating equipment left in out of normal line-up/abnormal equipment status.

Due to confusion over the controlling document for the tygon tube installation (work request and temporary alteration documentation both completed for this installation), QAP 300-S3, Jumper or Block Installation Record, will be revised to identify that a work request exists that is also associated with the installation.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on December 23, 1992 when the IM technician was counseled by IM management.

RESPONSE TO NOTICE OF VIOLATION
NRC INSPECTION REPORT
50-254/92028; 50-265/92028

OPEN ITEM: 254/92028; 50-265/92028

On December 13, 1992, a shift foreman, making a plant tour prior to shift turnover, noticed a new hose attached to the temporary domestic water supply to the 1A instrument air compressor. The hose was routed to a decontamination pad, but was not in use. Use of the hose could have impaired the adequacy of the cooling water supply to the 1A instrument air compressor, causing a trip of the compressor on high temperature. This would be an unnecessary challenge to Operations to maintain stable operating conditions. A similar concern regarding the loss of the same temporary cooling water supply was discussed in IR 254/265-92016, paragraph 10, and was made an open item (254/92016-03(DPR)). This further occurrence will also be tracked under that open item number. These two occurrences of poor activity control on a balance-of-plant system which could challenge plant operations were of concern to the inspectors.

COMMONWEALTH EDISON RESPONSE TO OPEN ITEM:

Temporary cooling water hoses were supplying cooling water from the domestic water system to the 1A and 1/2 Instrument Air Compressors. In the first incident, drawings for the domestic water system did not adequately portray the configuration of the domestic water system. When it was necessary to take part of the domestic water system Out of Service to tie in the new service building water system, a walkdown of the necessary isolation points was performed. During the walkdown, it was not determined that part of the system that was being isolated, went into the plant. The port of the system that went into the plant fed the hose for the temporary feed to the instrument air compressors.

The second incident dealt with a hose connected to the domestic water system that was to be used to decon equipment. This hose was connected by the Radiation Protection Department but had not been used. The Shift Foreman on his plant tour noticed the hose installation and immediately took actions to prevent its use.

CORRECTIVE ACTIONS TAKEN TO ADDRESS THE EVENT IDENTIFIED IN I.R. 254/92016-03

On June 25, 1992, Operating Department Memo 92-4, "Policy for the Performance of Out of Services (OOS's) and Knowing What the Results Will Be," was issued to Operating Supervision. The policy requires both the individual writing an OOS and SRO reviewing the OOS must have total confidence in the consequences of the OOS. If drawings do not adequately depict the situation and a walkdown is not feasible, then the OOS must be delayed until the situation can be resolved.

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CORRECTIVE ACTIONS TAKEN TO ADDRESS THE EVENT IDENTIFIED ON DECEMBER 13, 1992

On December 18, 1992, the Assistant Superintendent of Operations required each Shift Engineer to cover with his crew and the other department representatives at the shift briefings to be sensitive to preventing unauthorized temporary alterations. The operators and shift foremen are to look for and correct unauthorized temporary alterations found on their rounds.

On December 28, 1992, unauthorized temporary alterations were discussed at the Station's Department Head Meeting with the request to discuss these incidents at the weekly department tailgate meetings.

On February 17, 1993, the permanent cooling water source (Turbine Building Closed Cooling Water) was connected to the instrument air compressors, therefore alleviating this problem in the future.