



Commonwealth Edison  
1400 Opus Place  
Downers Grove, Illinois 60515

February 24, 1992

U.S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, D.C. 20555

Subject: Quad Cities Nuclear Power Station Units 1 and 2  
Response to Notice of Violation  
Inspection Report Nos. 50-254/91024; 50-265/91020  
NRC Docket Nos. 50-254 and 50-265

Reference: E.G. Greenman letter to Cordell Reed dated  
January 24, 1992 transmitting NRC Inspection  
Report 50-254/91024; 50-265/91020

Enclosed is Commonwealth Edison Company's (CECo) response to the subject Notice of Violation (NOV) which was transmitted with the referenced letter and Inspection Report. The NOV cited two Level IV violations related to a failure to make appropriate 10 CFR 50.73 Reports for two events and for inadequate procedures. A Level V violation was also cited for failure to adhere to procedures for wearing electronic dosimeters.

If your staff has any questions or comments concerning this letter, please refer them to Perry Barnes, Compliance Supervisor at 709/515-7278.

Very truly yours,

T.J. Kovach  
Nuclear Licensing Manager

Enclosure

cc: A. Bert Davis, Regional Administrator - Region III  
L. Olshan, Project Manager, NRR  
T. Taylor, Senior Resident Inspector - Quad Cities

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## ENCLOSURE

### RESPONSE TO NOTICE OF VIOLATION INSPECTION REPORT 50-254/91024; 50-265/91020

#### VIOLATION (254/91024-01a,b)

10 CFR 50.73 (a) (2) (v) requires that any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to remove residual heat, regardless of the plant mode or power level, and regardless of the significance of the structure, system, or component that initiated the event be reported to the NRC.

Contrary to the above:

- a. On April 24, 1991, during performance of a surveillance activity the reactor core isolation cooling system (RCIC) pump discharge valve (1-1301-49) failed to open. This event was not reported to the NRC.
- b. On December 1, 1991, during valve stroking activities the RCIC pump discharge valve (1-1301-49) failed to open. This failure was not reported to the NRC.

#### REASON FOR THE VIOLATION

These two instances where the RCIC 1-1301-49 valve failed to open were not reported to the NRC because of a misunderstanding on how to interpret the criteria for 10 CFR 50.73 (a)(2)(v). Operating Department personnel did not apply the additional guidance provided by Section 7 of NUREG 1022 Supplement 1. In this NUREG under question 7.9, it states that these events should have been reported regardless of operating mode or power level. This information is contained in the discussion section for the 10 CFR 50.73 (a)(2)(v) reporting criteria in QCAP 1780-3, "Deviation Report/Licensee Report/Deviation Investigation Report". Operations personnel failed to review this information when they made their determination on reportability. In the instances involved, the RCIC system was out of service at the time of discovery or the plant was in a condition where RCIC was not required to be operable. Because the system was not operable at the time of the event, the reportability was thought not to apply.

#### CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The April 24, 1991 failure and the December 1, 1991 failure will be reported to the NRC by Licensee Event Reports.

A review was conducted of the Deviation Reports written from 1990 to February 24, 1992, where the reactor was in Modes 1 or 2. This review identified two additional events that were mis-classified and should have been reported under 10 CFR 50.73(a)(2)(v). These events will be documented as License Event Reports and submitted to the NRC by March 24, 1992.

#### CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

A committee, consisting of representatives from various departments was initiated on January 27, 1992, to review station events on a daily basis. This includes reviewing these events for reportability to the NRC.

A letter has been sent to Operating Management personnel providing clarification of the 10 CFR 50.73 (a)(2)(v) reporting criteria.

These events and the NOV will be covered in the next license retraining sessions.

#### DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The Licensee Event Reports will be completed by March 24, 1992.

#### VIOLATION (254/91024-02)

Quad Cities Technical Specification 6.2.B, Plant Operating Procedures requires that radiation control procedures be maintained, made available to all station personnel, and adhered to.

Contrary to the above, on November 20 and 26, 1991, electronic dosimeters assigned to personnel working in the radiological control area were found unattended, and not worn as required by QRP 1001-1, Rev. 10.

NOTE: NOV lists QRP 1001-1, however, this QRP does not exist. The referenced procedure should be QRP 1000-1.

#### REASON FOR THE VIOLATION

Actions by the individual involved in the event were contrary to station policy and procedures.

#### CORRECTIVE STEPS AND RESULTS ACHIEVED

The specific incidents have been discussed with the individuals by their supervisors.

#### CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATION

- a. A letter was distributed to station personnel on January 13, 1992, discussing the proper use of dosimetry. Department supervisors will discuss this letter at future "tailgate" sessions.
- b. A copy of the same letter described above was reprinted in the station outage newsletter on January 15, 1992. This newsletter is distributed to personnel entering the plant.
- c. A separate letter was distributed to Radiation Protection personnel which described the proper response and documentation of lost dosimetry events. This letter was also discussed at a "tailgate" session to ensure that Radiation Protection personnel understand management's expectations on this issue.

#### DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved when the individuals involved were counseled on performance expectations by their supervisor.

#### VIOLATION (254/91024-05a,b)

10 CFR Part 50, Appendix B, Criterion V states, in part, that activities affecting quality shall be prescribed and accomplished in accordance with instructions of a type appropriate to the circumstances, which shall include acceptance criteria for determining that the activities have been satisfactorily accomplished.

Contrary to the above:

- a. On September 22, 1991, the return to service instructions utilized to return the Unit 2 reactor recirculation system motor-generator sets deluge fire protection header isolation valves (2-4199-174, 2-4199-175) to service did not appropriately prescribe repressurizing the fire headers after they had been isolated and drained.
- b. On December 9, 1991, the out of service instructions utilized to secure the 1A and 2A primary containment purge fan isolation dampers did not appropriately prescribe the orientation the dampers were to be secured in, nor did the instructions contain acceptance criteria for determining or verifying the activity had been satisfactorily accomplished.

#### REASON FOR THE VIOLATION

- a. Reactor Recirc MG Set Deluge

The Unit 2 reactor recirc MG set deluge system was taken out of service (OOS) to repair isolation valves in the system. The OOS was accomplished by closing a fire header isolation valve upstream of the deluge valves. When the return to service was performed, the fire header was pressurized without first pressurizing the deluge valve latching chamber which is necessary to keep the valve closed. The return to service instructions on the Master OOS checklist did not list the necessary sequence to achieve this result.

- b. Secondary Containment Boundary

The 1A and 2A Drywell/Torus Purge Fans were taken out of service on December 8, 1991, to perform filter replacement and sealing of the duct work. The OOS required securing the suction and discharge dampers in the closed position. The dampers were instead secured in the open position resulting in a pathway from secondary containment when the ductwork was opened. This was caused by inadequate verification of damper position due to lack of damper position indication.



## CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

### a. Reactor Recirc MG Set Deluge

This event has been tailgated to the operating crews to inform them of the cause of the deluge and the need to be aware of this potential condition.

### b. Secondary Containment Boundary

The purge fan damper linkages were secured OOS in the closed position. The remainder of the work on the system which required opening the ductwork was identified as a Heightened Level of Awareness activity to assure adequate controls and precautions were in place. Opening of the purge ductwork was treated as an opening of a secondary containment penetration.

## CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATION

### a. Reactor Recirc MG Set Deluge

Procedure QOP 4100-12, RESTORING PRESSURE TO THE FIRE MAIN, will be revised to include appropriate steps to pressurize deluge valves when refilling fire headers that have been isolation and drained.

Procedure QAP 300-14, EQUIPMENT OUT-OF-SERVICE, will be revised to include a general step for sequencing return to service of fire headers.

Pending completion of procedure revisions, the Fire Marshall is periodically reviewing out of services involving the fire protection suppression system to look for similar configurations and provide guidance for restoration of the system.

This events will be included in licensed and non-licensed operator retraining.

### b. Secondary Containment Boundary

The Drywell/Torus Purge Fan suction and discharge damper operators have been labeled to indicate open and closed position.

The Drywell/Torus Purge Fans and filters have been marked as a secondary containment boundary.

QCAP 230-5, INDEPENDENT VERIFICATION, will be revised to include discussion of the proper method of verification of ventilation damper position.

QCAP 200-11, HEIGHTENED LEVEL OF AWARENESS PROGRAM, will be revised to include reference to Secondary Containment work.

This event and the procedure changes will be included in licensed and non-licensed operator retraining sessions.

## DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The procedure changes and training will be completed by May 15, 1992.