



**Commonwealth Edison**

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Address Reply to: Post Office Box 767  
Chicago, Illinois 60690

September 12, 1985

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

Subject: Byron Station Unit 1  
I&E Inspection Report No.  
50-454/85-033

Reference (a): August 13, 1985 letter from C. J.  
Paperiello to Cordell Reed

Dear Mr. Keppler:

Reference (a) provided the results of an inspection by Mr. VanDenburgh from July 9 through July 26, 1985 at Byron Station. During this inspection, certain activities were found to be in violation of NRC requirements. Attachment A to this letter contains Commonwealth Edison's response to the Notice of Violation appended to reference (a).

Please direct any questions you may have regarding this matter to this office.

Very truly yours,

D. L. Farrar  
Director of Nuclear Licensing

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Attachment

cc: Byron Resident Inspector

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## ATTACHMENT A

### VIOLATION

10 CFR 50, Appendix B, Criterion II requires that a Quality Assurance program be established which will be documented by written policies and procedures and shall be carried out throughout plant life in accordance with these procedures. 10 CFR 50, Appendix B, Criterion XVI requires that measures be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances be promptly identified and corrected.

These criteria as implemented by the Commonwealth Edison Quality Assurance Manual, Quality Requirement 15.0, require that the Station Technical Staff investigate any deviation from accepted normal operation of a reactor and its associated equipment and issue a Deviation Report covering the nature of the deviation, its cause, the hazard or potential hazard to operations and recommendations for corrective action. As implementation of these requirements Quality Procedure 15-52 defines a Deviation as: "A departure from accepted equipment performance or a failure to comply with administrative controls or NRC requirements which results in, or could, if uncorrected, result in a failure of an item to perform as required by Technical Specifications or approved procedures." This Quality Procedure also requires that a Deviation Report be initiated for non-reportable events which represent a significant deviation from accepted normal operation of the reactor and associated equipment.

Contrary to the above, the licensee failed to initiate a Deviation Report following the occurrence of mechanically stuck control rods in Mode 5 on July 17, 1985. Although Technical Specifications require the control rods to be operational only in Modes 1 and 2, thermal binding of the control rods is considered to represent a significant deviation from accepted normal operation of the reactor's associated equipment.

### RESPONSE

In the process of performing a special test procedure to verify corrective action for the problem associated with control rod P-8, three other control rods failed to withdraw from the bottom of the core on demand. This occurrence was not reportable to the NRC since the unit was in Mode 5 and the Technical Specification operability requirements for the control rods apply only to Modes 1 and 2. Based on an interpretation of the "non-reportable event" guidance in the Commonwealth Edison Quality Assurance Manual, it was decided by station management not to classify this occurrence as a deviation. Nevertheless, prompt identification of the root cause of the problem was made and corrective action was immediately taken.

In retrospect, the station agrees that this occurrence of stuck control rods represented "...a significant deviation from accepted normal operation of the reactor and associated equipment..." and should have been formally classified as a deviation in accordance with the Commonwealth Edison Quality Assurance Manual.

Failure to classify this event as a deviation was an administrative documentation error which had negligible safety significance. The intended purpose of the deviation program is to promptly identify and correct malfunctions such as this. For the stuck control rods, the problem was investigated, the vendor consulted, the root cause determined and a special procedure was written and successfully executed to correct the problem within 24 hours of the occurrence. Exactly the same approach would have been taken to correct this problem if it was formally classified as a deviation. Substantively, the intent of the Deviation Report program was met and the error was in not documenting the problem on a Deviation Report form. In addition, the safety significance of these stuck control rods was negligible. The unit was in a mode for which control rod operability was not required by the Technical Specifications. Also, the control rods were stuck in their safest condition, at core bottom.

#### CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

Revision 1 to Deviation Investigation Report 6-1-85-193 "Control Rod P-8 Inoperabilities" was issued. The revision describes the occurrence of stuck control rods encountered during the investigation of the P-8 control rod problems.

#### CORRECTIVE ACTION TO PREVENT FURTHER VIOLATION

This violation and response will be placed in the required reading file for all licensed operators which includes Operating Department management personnel who make the final determination of classification of an occurrence as a deviation.

#### DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Revision 1 to Deviation Investigation Report 6-1-85-193 was issued on September 5, 1985. Licensed operators will read this violation and response by November 1, 1985.