Commonwealth Edison Company
Byron Generating Station
4450 North German Church Road
Byron, IL 61010-9794
Tel 815-234-5441

ComEd

June 19, 1997

LTR: BYRON 97-0142
FILE: 1.10.0101

U.S. Nuclear Regulatory Commission
Washington, DC 20555

Attention: Document Control Desk

Subject: Byron Nuclear Power Station Units 1 and 2
Response to Exercise Weaknesses
Inspection Report No. 50-454/97006; 50-455/97006
NRC Docket Numbers 50-454, 50-455

Reference: Cynthia D. Pederson letter to Mr. Graesser dated May 19, 1997, transmitting NRC Inspection Report 50-454/97006; 50-455/97006

Enclosed is Commonwealth Edison Company's response to the Exercise Weaknesses which were transmitted with the referenced letter and Inspection Report. The letter cited two (2) Exercise Weaknesses requiring a written response. ComEd's response is provided in the attachment.

This letter contains the following commitments:

1) The Station will evaluate increasing the number of NARs forms used and GSEP classifications during simulator training as the event escalates. This evaluation will also consider the disadvantage of distracting the SM from the training occurring on the simulator.

250092

IE35 1/1

(p:\97byltrs\970142.wpf\1)

If your staff has any questions or comments concerning this letter, please refer them to Don Brindle, Regulatory Assurance Supervisor, at (815)234-5441 ext.2280.

Respectfully,

K. L. Graesser

K. L. Graesser
Site Vice President
Byron Nuclear Power Station

KLG/DB/rp

Attachment(s)

cc: A. B. Beach, NRC Regional Administrator - RIII
G. F. Dick Jr., Byron Project Manager - NRR
S. D. Burgess, Senior Resident Inspector, Byron
R. D. Lanksbury, Reactor Projects Chief - RIII
F. Niziolek, Division of Engineering - IDNS
D. L. Farrar, Nuclear Regulatory Services Manager, Downers Grove
Safety Review Dept., c/o Document Control Desk, 3rd Floor, Downers Grove
DCD-Licensing, Suite 400, Downers Grove.

ATTACHMENT I

WEAKNESS (454/455-97006-01)

Exercise controllers properly delayed providing the first of the exercise's events (explosion in the crankcase of the 1B Diesel Generator) until testing of the diesels was begun. Control room operators immediately suspected trouble when the individual doing the testing ceased radio communication with the control room. Operators dispatched assistance to the individual injured in the explosion and learned that the explosion had not caused a fire. Shortly thereafter, operators observed that breaker 1414 had lost control power, and there had been a loss of all but one power supply to the Unit 1 Essential Safety Feature buses.

The Shift Engineer reviewed the plant Emergency Action Levels (EALs) several times but apparently focused on the diesel generator crankcase explosion and thus classified the event as an Unusual Event. Operators were aware of the degraded condition of the plant power supplies and had begun to analyze the extent of the degradation. A pro-active precautionary staffing of Technical Support Center (TSC) positions was requested to assist in evaluating the overall condition of the plant.

The loss of all but one power supply to the Unit 1 Essential Safety Feature buses warranted the classification of an Alert per EAL MA1, "Power to ESF buses reduced to a single power source for ≥ 15 minutes". When this classification was not made within a reasonable period of time (15 minutes), a controller prompted the participants to make the classification to preserve the scenario time line. The failure to properly classify the accident scenario at the highest appropriate classification level was an Exercise Weakness that will be tracked as Inspection Followup Item 50-454/97006-01; 50-455/97006-01. Technical Specification 6.8.1 requires, in part, that written procedures shall be established, implemented, and maintained covering activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978.

REASON FOR THE WEAKNESS

During the 1997 GSEP exercise, the Shift Manager classified an event as an Unusual Event versus the anticipated Alert. This was attributed to a difference in opinion regarding operability of a 4Kv breaker.

The Shift Manager did not make the proper event classification within the 15 minute requirement, but at 22 minutes the Lead Controller provided a contingency message to the Shift Manager to make an Alert classification. The Technical Support Center (TSC), at this time, was staffing and making initial EAL evaluations when this contingency message was issued.

An interview with the Shift Manager who classified the event found that the Shift Manager was focused on an injured person and did not detect the breaker problem. When the Shift Manager became aware of the loss of breaker control power, he reasoned that the power source was still operable because it could be locally closed (the reserve breaker does not have an auto-close feature).

The apparent cause is that the Shift Manager took credit for local operator action in deciding that the breaker could be closed locally.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

1. None

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER WEAKNESS

1. To address this concern, the Station will evaluate increasing the number of NARs forms used and GSEP classifications during simulator training as the event escalates. This evaluation will also consider the disadvantage of distracting the SM from the training occurring on the simulator. This action will be tracked by NTS# 454-201-97-CAQS01500-01.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance will be achieved by 8/15/97 when the evaluation is completed.

ATTACHMENT II

WEAKNESS (454/455-97006-02)

Once the Alert was declared, the Shift Engineer failed to utilize the Acting Station Director checklist included as an attachment to Emergency Plan Implementing Procedure (EPIP) BZP 310-5, "Acting Station Director or Station Director", Rev. 23, and associated checklist, BZP 310-5T1, "Acting Station Director Checklist", Rev. 2. The Acting Station Director Checklist indicated that it is to be used as a guide by the Acting Station Director to assist in the completion of emergency responsibilities and duties.

One of the BZP 310-5T1 checklist items (Step 5), initiation of the Emergency Response Data System (ERDS) as soon as possible but no later than one hour following an Alert classification or higher, was overlooked by the control room staff but was caught during checklist verification in the TSC.

The failure to utilize the Acting Station Director procedure and associated checklist was an Exercise Weakness that will be tracked as Inspection Followup Item 50-454/97006-02; 50-455/97006-02.

REASON FOR THE WEAKNESS

The Alert was classified at 0835 by the Shift Manager. The Technical Support Center (TSC) was staffing, and activated the Emergency Response Data System (ERDS) at 0850. This is within the regulatory requirement of one hour from event classification, and shortly thereafter, the TSC assumed Command and Control at 0909.

The failure of the Shift Manager (SM) to use the checklist was attributed to the fact that the SM was comfortable in his knowledge of the requirements for an Unusual Event. The apparent cause of the failure to use the checklist is that the event was misclassified and the SM felt the checklist was not required for the lower level event.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

1. The requirements of procedure adherence were discussed with the Shift Manager.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER WEAKNESS

1. None

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.