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SUBJECT: Responds to NRC 970204 ltr re violations noted in insp rept
 50-315/96-13 & 50-316/96-13. Corrective actions: instructions
 requiring filter content evaluation were removed from
 charging pump recurring tasks on 970211.

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March 12, 1997

AEP:NRC:1238F
10 CFR 2.201

Docket Nos.: 50-315
50-316

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

Gentlemen:

Donald C. Cook Nuclear Plant Units 1 and 2.
NRC INSPECTION REPORTS NOS. 50-315/96013(DRS)
AND 50-316/96013(DRS) REPLY TO NOTICE OF VIOLATIONS

This letter is in response to a letter from G. E. Grant, dated February 4, 1997, that forwarded a notice of three violations and one notice of deviation to Indiana Michigan Power Company. The violations and the deviation were identified during a system operational performance inspection (SOPI) of the centrifugal charging system portion of the emergency core cooling systems and the residual heat removal systems.

Our response was due to you on March 6, 1997; however, we requested a brief extension to recover the time delay from when the report was issued to when it was received. The extension was granted by Ron Gardner of Region III, on February 14, 1997.

The three violations addressed the 1) failure to establish adequate instructions/failure to follow procedures as related to collection of an oil sample, and adequate minimum thread engagement acceptance criteria; 2) inadequate test control as related to incorporating charging pump acceptance limits into the IST program; and 3) failure to perform adequate/timely corrective actions, as related to determining the correct oil sight-glass fill marks on safety-related pumps and motors, addressing equipment deficiency tagging problems, and locating/reconstituting a centrifugal charging pump net positive suction head calculation.

The deviation was from actions committed to in NUREG-0737 specifically involving the source term used for a radiological evaluation.

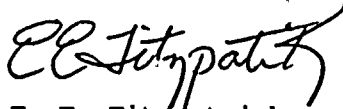
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Our reply to the violations and deviation are provided in the attachment to this letter. Also included are the results of our review of technical specification clarifications, which we committed to perform at the December 13, 1996, exit meeting. The reply does not contain any personal privacy, proprietary, or safeguards information.

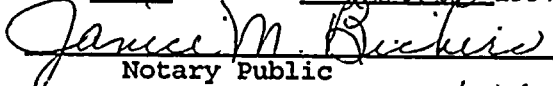
Sincerely,



E. E. Fitzpatrick
Vice President

SWORN TO AND SUBSCRIBED BEFORE ME

THIS 12 DAY OF March, 1997


Notary Public

My Commission Expires: 2/16/2001

vlb

Attachment

JANICE M. BICKERS
Notary Public, Berrien County, MI
My Commission Expires Feb. 16, 2001

cc: A. A. Blind
A. B. Beach
MDEQ - DW & RPD
NRC Resident Inspector
J. R. Padgett

ATTACHMENT TO AEP:NRC:1238F
REPLY TO NOTICE OF VIOLATION:
NRC INSPECTION REPORTS NOS. 50-315/96013 (DRS)
AND 50-316/96013 (DRS)



During an NRC system operational performance inspection conducted November 18 through December 13, 1996, on the emergency core cooling system portion of the centrifugal charging system and residual heat removal system three violations and one deviation were identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," (NUREG-1600) the violations and the responses are provided below. Additionally, we were requested to respond to the deviation, and to provide information related to a commitment regarding technical specification (T/S) clarifications made at the December 13, 1996, exit meeting. Our response to these items is also provided below.

NRC Violation A

"10 CFR 50, Appendix B, Criterion V, 'Instructions, Procedures, and Drawings,' requires, in part, that activities affecting quality shall be prescribed by instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

Maintenance procedure 12 MHP 5021.001.009, Revision 8, 'Torque Selection,' dated March 21, 1994, requires thread engagement of at least 80 percent of nut height.

Contrary to the above:

1. On December 4, 1996, the inspectors identified that a maintenance work package for the 1E centrifugal charging pump, an activity affecting quality, failed to include adequate instructions for lube oil sample collection.
2. On November 20, 1996, the inspectors identified that maintenance procedure MDS-600, 'General Erection Tolerances for Pipe and Tube Supports/Restraints,' was not of a type appropriate to the circumstances since it failed to contain adequate minimum thread engagement acceptance criteria for activities affecting quality.
3. On November 21, 1996, the inspectors identified that maintenance personnel failed to perform bolting on safety-related equipment in accordance with maintenance procedure 12MHP5021.001.009, 'Torque Selection.' As a result, nuts associated with emergency core cooling system equipment were identified with thread engagement less than 80 percent of nut height.

This a Severity Level IV violation."

Response to NRC Violation A1

1. Admission or Denial of the Alleged Violation

Indiana Michigan Power Company admits to the violation as cited in the NRC notice of violation.

2. Reason for the Violation

The reason for the violation was failure to remove oil sampling instructions from applicable recurring tasks that were no longer needed after implementation of a formal oil sampling program.



The instructions found in the job order activity associated with the work on the 1E centrifugal charging pump instructed personnel to:

"Drain oil from filter into a container:

A. Deliver oil from CUNO filter to chem lab for analysis. (The results will go to the engineers for evaluation of wear in system)."

The job order activity instructions were developed prior to implementation of our formal oil analysis program. At the time it was input as a recurring task, it was intended to provide a rough indication of gross machine problems. Subsequently, a formal oil analysis program was implemented, with proceduralized sampling techniques being utilized by chemistry personnel. Under this sampling program, done quarterly (as opposed to filter change-outs that are done yearly), wear particles of considerably less size than those detected via the filter change-out method can be detected, thus giving much earlier indication of machine problems.

The instructions in the recurring task were inadvertently left in place after the formal program was instituted. The oil collected via these instructions is not analyzed by chemistry personnel; and decisions as to the condition of the equipment are not based on these samples.

3. Corrective Actions Taken and Results Achieved

The instructions requiring filter content evaluation were removed from the charging pump recurring tasks on February 11, 1997. The 1E charging pump lube oil was sampled by chemistry personnel on September 12, 1996, prior to the filter change-out observed on December 4, 1996, consistent with the formal oil analysis program.

4. Corrective Actions Taken to Avoid Further Violations

A review of lube oil changes related to equipment included in the oil analysis program was conducted. Similar wording was found in recurring tasks for the motor-driven and turbine-driven auxiliary feedwater pumps. This redundant wording will be removed prior to the next required date for filter change-out for this equipment.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on February 11, 1997, when the redundant instructions were removed from the four charging pump's recurring tasks.

Response to NRC Violation A2 & A3

1. Admission or Denial of the Alleged Violation

Indiana Michigan Power Company admits to the violation as cited in the NRC notice of violation.

2. Reason for the Violation

The cause of the violation, as cited in A3, is a combination of the way work was documented and adherence to procedural requirements that were inconsistent.

The reference to MDS-600, cited in A2, as a "maintenance procedure" requires clarification. MDS-600 is not a procedure, it is a design standard that provides tolerances for installation and evaluation of as-found conditions for piping/tubing supports. MDS-600 is not an applicable reference and there is no hierarchical connection between MDS-600 and **12 MHP 5021.001.009.

3. Corrective Actions Taken and Results Achieved

Eight condition reports were written to document the inspection team's concerns. Operability reviews were performed based on the identified deficiencies, and the affected equipment was determined to be operable.

Work history for each component was reviewed to assist in determining the potential cause(s). In general, this review identified a general time frame when the deficiency was created, but not a specific work activity.

Action requests were written to correct the deficiency where an action request did not already exist, or the deficiency was evaluated and found to be acceptable as is.

4. Corrective Actions Taken to Avoid Further Violations

Maintenance standing order, MSO.009, was issued on February 3, 1997. This document establishes an acceptance criteria of "flush or better" for thread engagement. Further, it provides a policy for documenting as-found thread engagement deficiencies so they can be evaluated and corrected.

Lastly, the policy provides for in-plant identification of less than flush thread engagement that has been evaluated and found to be acceptable. This standing order strengthens management expectations for thread engagement and establishes a mechanism for identification of analyzed, acceptable conditions.

A walkdown was performed of a random sample of plant components of sufficient size to provide a 99% confidence level that these components are a statistically valid sample of the plant population of components. The as-found configuration of the fasteners associated with these components was evaluated. There were no fastener anomalies identified that affected component functionality or operability.

Plant management has reinforced procedural adherence to all plant personnel.

**12 MHP 5021.001.009 was enhanced by the addition of acceptance criteria of flush threads or better.



5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on March 10, 1997. At that time the original 28 NRC-identified thread engagement deficiencies were analyzed as not affecting operability/quality; existing procedures, policies, and standards were upgraded; and the findings of the thread engagement random sample concluded that there were no functionality/operability concerns caused by thread engagement deficiencies associated with any of the sampled components.

NRC Violation B

"10 CFR 50, Appendix B, Criterion XI, 'Test Control,' requires, in part, that a test program be established to assure that all testing required to demonstrate that structures, systems, and components will perform satisfactorily in service is identified and performed in accordance with written test procedures which incorporate the requirements and acceptance limits contained in applicable design documents.

Technical Specification 3.1.1.1, 'Shutdown Margin - Tave greater than 200 °F,' specifies a boration capability of 10 gallons per minute (gpm) of 20,000 parts per million (ppm) boron solution or equivalent.

Contrary to the above, on December 11, 1996, the inspectors identified that the correct acceptance limits to assure that the centrifugal charging pumps could perform their boron injection function as specified in Technical Specification 3.1.1.1 had not been incorporated in the licensee's inservice testing (IST) program.

This is a Severity Level IV violation."

Response to NRC Violation B

1. Admission or Denial of the Alleged Violation

Indiana Michigan Power Company admits to the violation as cited in the NRC notice of violation.

2. Reason for the Violation

The reason for the violation was that a review to determine applicability to the IST program was not conducted prior to issuance of a technical specification (T/S) clarification on T/S 3.1.1.1.

T/S 3.1.1.1, Shutdown Margin - T_{avg} greater than 200°F provides shutdown margin requirements while in modes 1, 2, 3, or 4. The action statement for T/S 3.1.1.1 requires immediate and continuous boration at greater than or equal to 10 gpm of a solution containing greater than or equal to 20,000 ppm boron or "equivalent". Westinghouse performed an analysis to clarify the meaning of this statement if the refueling water storage tank (RWST) was used as a source of borated water. Westinghouse defined "equivalence" as "xenon burnout equivalence", which is the capability to inject sufficient boron to adjust boron concentration to compensate for xenon burnout from its peak value. Their analysis assumed a plant trip followed by a step return to 100% power

at peak xenon concentration. In addition, they assumed that the reactor would be maintained at full power during the transient. The results of this analysis showed that a centrifugal charging pump (CCP) flow of 120 gpm from the RWST could compensate for xenon throughout the transient if certain restrictions were observed.

On November 5, 1990, a revision to T/S clarification no. 7 was issued, which defined the 120 gpm of RWST water containing 2400 ppm boron as an acceptable source of water to satisfy boration flow requirements for T/S 3.1.1.1. Development and issuance of this T/S clarification was not coupled with a review of the test program to ensure the test program confirmed the ability of the CCPs to perform this function. This deficiency was identified by our engineers during efforts to respond to an inspector's question on the design functions of the CCPs during the inspection.

3. Corrective Actions Taken and Results Achieved

Following identification of this deficiency, a calculation was performed to determine the maximum degradation the CCPs could tolerate while still being able to deliver 120 gpm of RWST water to the reactor coolant system. This calculation revealed that the CCPs could tolerate a degradation of 9.5% for Unit 1 and 3.5% for Unit 2. A review of IST data as far back as 1990 determined that the pumps were capable of performing this function. The IST program has been revised to include limitations for allowable degradation of the CCPs to ensure that 120 gpm of 2400 ppm boron could be supplied from the RWST.

Additionally, as a point of information, since the original analysis by Westinghouse, which defined the 120 gpm value of 2400 ppm boron included a very conservative assumption that a step increase in power to 100% occurred while at peak xenon, a reanalysis was performed using a more realistic ramp rate of 10%/hr, which is a limitation contained in plant procedures. This reanalysis indicated that the boration flow requirements of T/S 3.1.1.1 could be satisfied by as little as 60.1 gpm of 2400 ppm boron. We may relax the allowable degradation for the CCPs based on this revised 60.1 gpm flow.

4. Corrective Actions Taken to Avoid Further Violations

Failure to ensure the test program for the CCPs included provisions to ensure the CCPs could deliver 120 gpm of 2400 ppm boron occurred as a result of failure to couple the development and issuance of a T/S clarification with appropriate reviews of the test program. As noted in the SOPI report, several examples were identified where T/S clarifications could not be justified. During the exit meeting, we committed to perform a review of all of our T/S clarifications. The results of this review are contained in the "Commitment" section of this attachment. Additionally, as noted, improvements will be made in the T/S clarification review process to ensure an adequate technical review of future clarifications.



5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on December 18, 1996, when the IST program was revised to include appropriate limits to ensure that each units' CCPs can supply 120 gpm of 2400 ppm boron from the RWST.

NRC Violation C

"10 CFR 50, Appendix B, Criterion XVI, 'Corrective Actions,' requires, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.

Contrary to the above:

1. Corrective actions to address potentially inaccurate sight-glass fill marks for safety-related pumps and motors, a condition adverse to quality, were not initiated until November 27, 1996, although in 1995 job orders were written to address potentially inaccurate sight-glass fill marks on safety-related pumps and motors, and on March 6, 1996, an action request was written to determine correct sight-glass fill marks on safety-related pumps and motors.
2. On December 5, 1996, the inspectors identified that the licensee failed to take corrective actions to either locate or re-constitute a centrifugal charging pump net positive suction head (NPSH) calculation although the calculation had been identified as missing about 18 months earlier.
3. On December 4, 1996, the inspectors determined that the licensee failed to take timely corrective actions to address equipment deficiency tagging problems. Although the licensee had identified that about 30 percent of plant components in the work control system reviewed in a three week period were not properly tagged in the field, corrective actions to address this concern had not been initiated.

This is a Severity Level IV violation."

Response to NRC Violation C1

1. Admission or Denial of the Alleged Violation

Indiana Michigan Power Company admits to the violation as cited in the NRC notice of violation.

2. Reason for the Violation

The cause of the untimely response for guidance on plant pump/motor oil fill levels was the lack of a communication protocol resulting in an unrecognized request to engineering personnel from operations personnel for technical assistance. The request for assistance was made by means of an action request. Requests for engineering direction are made within the nuclear plant maintenance (NPM) computer system by means of an evaluation request. Different searches are required to locate action requests and evaluation requests. Engineering personnel did not search action requests because they were not an expected means for requesting assistance.



The request for guidance on plant pump/motor oil fill levels was brought to engineering management's attention approximately five months after the action request was initiated. At that time engineering personnel began work to provide the requested guidance. The background research was completed and the guidance issued on December 5, 1996.

3. Corrective Actions Taken and Results Achieved

The requested information on pump/motor oil fill levels was provided on December 5, 1996. A search of action requests assigned to engineering personnel has been performed to ensure the responsible groups are aware of assignments. Additionally, as an interim action, plant personnel have been instructed to make daily searches to ensure no new action requests for engineering assistance go unrecognized.

4. Corrective Actions Taken to Avoid Further Violations

An acceptable method for requesting engineering assistance will be developed by March 21, 1997.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on December 5, 1996, when the requested technical guidance was provided.

Response to NRC Violation C2

1. Admission or Denial of the Alleged Violation

Indiana Michigan Power Company admits to the violation as cited in the NRC notice of violation.

2. Reason for the Violation

In June 1995, as part of the design basis documentation (DBD) program, it was identified that the NPSH calculation for the CCPs could not be located. A DBD action item was initiated in accordance with DBD program procedures. This item was classified as an instance of a "missing reference document", a categorization with a normal resolution time of 60 days.

Engineering personnel involved in the classification of this item were aware that an NPSH calculation for the CCPs had been performed at one time, even though it could not be located. Operability was not considered to be a concern because it was known that the calculation had been performed but could not be found. Therefore, a high priority was not placed on reconstituting the calculation or resolving the DBD action item.

3. Corrective Actions Taken and Results Achieved

As noted in the SOPI report, a new calculation was completed prior to and approved during the SOPI inspection, which confirmed adequate NPSH to the CCPs.

4. Corrective Actions Taken to Avoid Further Violations

Following the SOPI inspection, a review of all open DBD action items was performed, by January 15, 1997, to assess

the appropriateness of their classification. A series of additional DBD action items were formally entered into the corrective action system (via condition reports) as a result of this review. The corrective action system includes requirements for determining operability in a timely manner. Entry into the corrective action system ensures a review of these issues by our condition assessment group (CAG). In its oversight function, the CAG assesses the need and makes assignments for confirmatory operability determinations or supplemental analysis.

Beginning in January 1997, additional resources were added to the DBD project to enable prompt closure of DBD action items. Specifically, the DBD project manager position, which had been vacant since September 1996, was filled and two additional utility personnel and two contract personnel were assigned to the project. These personnel are aggressively pursuing resolution of open DBD action items. This augmentation of personnel will continue through late 1997, by which time we expect to have made significant progress in the closure of DBD action items.

Additionally, we are training members of our staff, who have ownership of the DBDs, to ensure they understand the importance of promptly resolving DBD action items and also to ensure they clearly understand the process for effecting closure of these items. This training commenced in early February 1997 and will be completed by March 15, 1997.

Finally, the DBD action item review process is being strengthened to limit the number of available classifications for DBD action items and also to ensure a more comprehensive review of action items by appropriate personnel. Project instructions related to action item processing are being revised. These revisions will be completed by March 28, 1997.

5. Date When Full Compliance Will Be Achieved

Full compliance was achieved on December 2, 1996, when a new calculation was approved which confirmed adequate NPSH to the CCPs.

Response to NRC Violation C3

1. Admission or Denial of the Alleged Violation

Indiana Michigan Power Company admits to the violation as cited in the NRC notice of violation.

2. Reason for the Violation

The primary reason for the violation is that plant personnel were not sufficiently aware of the guidance regarding when to hang deficiency tags for corrective maintenance. This was further compounded by the lack of clarity provided by the administrative requirements that define deficiency tag hanging requirements.

Further, condition reports were not generated when missing deficiency tags were identified to prompt appropriate actions via the plant's corrective action program. While written



memoranda identifying the missing deficiency tags were generated, condition reports were not written and therefore appropriate attention and follow-through were not instituted.

In all cases evaluated, the work control process had captured the identified degraded component, ensuring that the deficient condition would be corrected in a timely manner.

3. Corrective Actions Taken and Results Achieved

Recent plant management actions have been taken to improve focus on promptly identifying problems and corrective actions dealing with conditions adverse to plant requirements. A condition report was promptly written when the NRC noted the lack of timely corrective action to address the identified deficiency tagging issue. The condition report 1) proposes that the material condition group replace missing tags when discovered, 2) recommends changes to the governing document NPM-02CM, and 3) requests assistance from computer personnel to modify existing NPM software to better support the rehang of tags.

The personnel responsible for identifying missing deficiency tags were coached on the expectation to generate additional condition reports in the future.

4. Corrective Actions Taken to Avoid Further Violations

By April 1, 1997, the governing document detailing when and how to tag deficiencies will be revised and appropriate personnel will be made aware of the revised requirements. Also, as of April 1, 1997, action requests generated that have not met the revised deficiency tagging requirements will be returned to the originating personnel for resolution before the action request will be processed further.

By September 1, 1997, system walkdowns will have been performed to verify that deficiency tags associated with existing corrective maintenance action requests (those generated before April 1, 1997), comply with the revised requirements.

5. Date When Full Compliance Will Be Achieved

Full compliance will be achieved by April 1, 1997, when the deficiency tagging requirements have been revised and appropriate personnel have been made aware of those requirements.

Further, condition reports will be written as of April 1, 1997, for any deficiency tag not in compliance with the revised requirement (regardless of when the action request and associated deficiency tags were generated).

Deviation

In addition to the above three violations, the notice of violation contained the following notice of deviation, which is addressed below.

DEV 50-315/96013-09(DRS) and DEV 50-316/96013-09(DRS)

"During an NRC inspection conducted November 18 through December 13, 1996, a deviation of your actions committed to in NUREG-0737, Section II.B.2 was identified. In accordance with the 'General Statement of Policy and Procedures for NRC Enforcement Actions,' NUREG-1600, the deviation is listed below:

NUREG-0737, Section II.B.2, 'Design Review of Plant Shielding and Environmental Qualification of Equipment for Spaces/Systems Which May Be Used in Postaccident Operations,' requires that 50 percent of the total iodine and 100 percent of the noble gases are assumed to be released from the fuel in the design basis accident radiological analysis.

Contrary to the above, on December 4, 1996, the inspectors identified that the licensee failed to correctly translate Section II.B.2 of NUREG-0737 into the centrifugal charging pump emergency leakoff valve failure design basis accident radiological analysis. As a result, only one percent fuel damage was assumed in the analysis and resulted in dose estimates lower than revised calculated values."

Response to NRC Deviation1. Reason for the Deviation

In August 1991, a small break loss of coolant accident scenario run on the plant simulator identified a flowpath that had the potential to divert water away from the emergency core cooling system and containment building. The flowpath was from the safety injection system (SIS) centrifugal charging pump discharge through an emergency leakoff valve, through the reactor coolant pump (RCP) seal return line safety valve to the volume control tank (VCT) and through the VCT safety valve to the chemical and volume control system holdup tanks. This condition was documented in LER 91-007-00. A review was conducted to assess the safety consequence and implications of the postulated event. Analysis of the potential dose rate from the diverted water to the whole body at the site boundary was calculated to be insignificant compared to the 10 CFR 100 accident dose limit and even with the 10 CFR 20.105 dose limits for unrestricted areas during normal operations, based on the assumption of 1% failed fuel.

LER 91-007-01 provided original corrective action for this scenario. The scenario of concern occurs following the switchover of the CCP suction from the refueling water storage tank to the recirculation sump via the residual heat removal (RHR) pumps. With the RHR pumps supplying suction to the CCPs, the pressure in the CCP emergency leakoff (ELO) lines could be in excess of the downstream safety valve set pressure, and then approximately 60 gpm flow would be diverted from the ECCS to the VCT. Corrective actions for this scenario included emergency operating procedure (EOP)

modifications to close the charging pump ELO valves as part of the switchover from injection to recirculation phase where the ECCS pumps take suction from the recirculation sump.

In June 1995, as part of our DBD program, it was identified that the EOPs noted above can be implemented, but were not single failure proof. The DBD program includes a process to identify, classify (with respect to safety significance), and resolve action items identified during the development of DBDs. A DBD action item was created to document that in the event the single failure is an ELO valve that cannot be isolated, the leakage path to the VCT would still persist. Within the DBD program, this issue was classified as a discrepancy that was not safety significant, based on the analysis described above and documented in LER 91-007.

The reliance on the prior analysis in LER 91-007, which provided a practical assessment of safety significance per 10 CFR 50.73, to classify the DBD action item as a non-significant discrepancy was incorrect because it did not consider design basis assumptions for source term per NUREG-0737. The misclassification of the DBD action item was made by engineering personnel who incorrectly assumed that the analysis presented in LER 91-007 was also an adequate basis for classification of the DBD action item.

2. Corrective Actions Taken and Results Achieved

The EOPs have been modified to instruct the operator to turn off a CCP for which the ELO valve cannot be closed. Flow through the idle pump of up to 5.2 gpm may still exist; therefore, instructions have been added to isolate the valve manually. (The 5.2 gpm is within the 10 gpm value for outside containment leakage previously evaluated and determined acceptable regarding offsite and control room doses.) The maximum dose to personnel expected to isolate the valve is 0.28 rem 24 hours after the accident occurs.

3. Corrective Actions Taken to Avoid Further Deviations

Following the SOPI inspection, a review of all open DBD action items was completed on January 15, 1997, to assess the appropriateness of their previous classification. A series of additional DBD action items were formally entered into the corrective action system as a result of this review. Entry into the corrective action system ensures a thorough screening of these issues by the CAG for assignment to the appropriate organization for resolution. The corrective action system includes requirements for determining operability in a timely manner. In its oversight function, the CAG assesses the need and makes assignments for confirmatory operability determinations or supplemental analysis.

The DBD action item review process is being strengthened to limit the number of available classifications for DBD action items and also to ensure a more comprehensive review of action items by appropriate personnel. Project instructions related to action item processing are being revised. These revisions will be completed by March 28, 1997.

4. Date When Full Compliance Will Be Achieved

Corrective action was completed on December 13, 1996, when changes were made to the EOPs to instruct the operator to turn off a CCP for which the ELO valve cannot be closed.



Commitment

The inspection report requested we respond in writing regarding our review of T/S clarifications. The notice of violation contained the following discussion.

"The licensee had 37 technical specification clarifications (TSCs) in effect. The inspectors reviewed the TSCs listed below and questioned whether the licensee could provide technical justification to support the TSCs. Subsequently, the licensee determined that the following clarifications could not be technically justified and should be canceled:

TSC #14	Airborne Radioactivity Monitor Operability
TSC #15	Diesel Generator Surveillance Runs - Paralleled Grid
TSC #48	Technical specification (TS) 4.8.1.1.2.F.2 Leak Testing of AD and CD Fuel Oil Tanks and Associated Piping

The inspectors did not identify any past use of the above TSCs that resulted in exceeding the action requirements of the associated technical specification. The inspectors concluded that the safety significance of the TSC errors were minimal.

The inspectors concluded that the licensee's approval of TSCs without appropriate technical justification was a weakness. At the end of the inspection, the licensee committed to review all remaining TSCs to ensure they were still necessary and could be justified."

Review Scope

The NRC inspection report indicated that 37 TSCs were in effect at the time of the inspection. A review of the active TSCs from the TSC index indicated that there were actually 35 active TSCs.

The three TSCs discussed in the inspection report were canceled. The scope of the TSC review was of the remaining 32 active TSCs.

Observation and Findings

Nine TSCs were canceled. They are as follows.

TSC #5	Operable - Operability Definition - Attendant Instrumentation
TSC #12	D.C. Distribution - Operating
TSC #26	Steam Generator Stop Valve Operability
TSC #37	Definition of Maintenance on Emergency Core Cooling System Valves
TSC #38	Turbine Driven Auxiliary Feedwater Pump Operability
TSC #45	Snubber Functional Test Retest Results
TSC #47	10 CFR 50 Appendix R Equipment Operability
TSC #60	Auxiliary Feedwater System and Essential Service Water System
TSC #61	Auxiliary Feedwater System Surveillance Requirements

Of this group, two TSCs (#5 and #12), were canceled due to insufficient technical bases to support the implied operability provided by the TSC. Three TSCs (#37, #60 and #61), were canceled

as they were implemented in a manner inconsistent with current expectations. Four TSCs (#26, #38, #45 and #47) were determined to be unnecessary.

One TSC (#65), boric acid transfer pump operability, was revised to properly reflect its technical bases (refer to section 08.1 of the NRC inspection report).

The remaining 22 TSCs remain active.

Conclusion

Based on the review of the existing TSCs, it follows that the TSCs were not well defined and were implemented in a manner inconsistent with current expectations. The program was utilized to capture many event driven decisions that would more appropriately fit an operability program, or should be translated into approved procedural controls.

An improved TSC program will be developed by June 27, 1997. This program will provide a review of proposed new clarifications to ensure adequate technical justification is present prior to approval, and that a clarification does not change or alter the requirement of the specification being clarified.

Additionally, the new program will require plant impact reviews as part of the implementation process. The impact reviews will ensure appropriate review and incorporation of clarification information into plant procedures and programs. The impact review process is being incorporated into the implementation process to address a SOPI concern involving integration of TSC #7 into the plant's IST program.

