Dominion Nuclear Connecticut, Inc.
Millstone Power Station
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Dominion

June 24, 2005

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

Serial No. 05-311
NSS&L/DWD R1
Docket No. 50-423
License No. NPF-49

DOMINION NUCLEAR CONNECTICUT, INC.
MILLSTONE POWER STATION UNIT 3
RESPONSE TO NRC INTEGRATED INSPECTION REPORT 05000336 AND 05000423/2005002

Dominion Nuclear Connecticut, Inc. (DNC) has reviewed the matters identified as Non-Cited Violations (NCV) in the subject inspection report. DNC respectfully denies two of the NCVs identified for Millstone Unit 3 (MPS3). On June 10, 2005 DNC was granted a 14-day extension on the required response date for these items.

The basis for denial of the NCVs is described in Attachments 1 and 2. Should you have any questions regarding this matter please contact Mr. David W. Dodson at 860-447-1791, extension 2346.

Very truly yours,

Eugene S. Grecheck
Vice President – Nuclear Support Services

Attachments (2)

Commitments made in this letter: None

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ATTACHMENT 1

DENIAL OF NON-CITED VIOLATION
05000423/2005002-02

MILLSTONE POWER STATION UNIT 3
DOMINION NUCLEAR CONNECTICUT, INC.

Restatement of NCV

"Introduction. The inspector identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for Dominion's failure to take prompt and appropriate corrective actions to evaluate and correct a degraded condition associated with the divider plate for all three RPCCW HXs.

Description. On May 20, 2003, engineering identified a bent divider plate in the B RPCCW HX. The divider plate was deflected approximately ½ inch from centerline to the outlet SW side. The divider plate separates the inlet SW flow from the outlet SW flow and ensures that the incoming SW flow is routed to the tube side of the two-pass RPCCW HXs. Engineering initiated CR-03-04924 that included actions to straighten the divider plate, inspect the "A" and "C" RPCCW HXs, modify their HX inspection form to include a divider plate inspection step, and to develop and implement a modification to strengthen the divider plate.

On June 9, 2003, engineering found a deflected divider plate in the "C" RPCCW HX and a deflected divider plate in the "A" RPCCW HX on June 25, 2003. Engineering determined that high differential pressure (d/p) across the divider plates due to tube plugging caused the plates to bend. In addition, Engineering reviewed the May 2003 operating experience (OE) information from D.C. Cook that discussed catastrophic failure of a component cooling water HX divider plate due to repeated divider plate deflections (OE16319). Based on the above information, engineering proposed a modification to stiffen the RPCCW HX divider plates through their Engineering Level of Effort (LOE) process. Maintenance used mechanical means to straightened the divider plate in each HX; however, engineering found the divider plate deflected again on subsequent HX inspections ("A" HX on May 23, 2004; "B" HX on September 9, 2004 and December 1, 2004).

The inspector noted that engineering had treated each of the six instances of deflected divider plates discovered since May 2003 in a "broke-fixed" manner without evaluating the degraded condition for continued operability of the RPCCW HXs. Given the degraded condition of the divider plates deflecting over time and potentially causing fatigue failure of the divider plate welds, and the industry OE documenting the failure of a similar HX under operating conditions, the inspector determined that engineering should have promptly evaluated and documented their basis for a reasonable expectation of operability.

Engineering designated the divider plate stiffening modification as a low priority item. The inspector noted that Engineering extended the due date for the associated LOE review seven times since August 2003, and in March 2004 deferred the activity out to

2005. Presently, the Engineering portion of the modification package is scheduled to be completed by September 2005. The inspector determined that the timeliness of Dominion's corrective actions were not commensurate with the potential safety significance of the issue. The inspector found no evidence that Dominion evaluated the effects on operability or the significance of the degraded condition when extending the corrective actions well beyond their first opportunity to correct.

The inspector also identified that Dominion failed to implement their corrective action assignment (CR-03-04924/03003369-05) to revise the SW cooled HX inspection form, although they closed out this action as complete in September 2003 (CR-05-01233). On February 10, 2005, Engineering initiated CR-05-01281 to evaluate additional information concerning the RPCCW HX divider plates. Subsequently, on February 25, Engineering initiated CR-05-01767 to evaluate an elevated RPCCW HX DP (23 psid as compared to a 20 psid design) observed by the RPCCW system engineer during two SW pump operation during SW surveillance testing. Engineering performed an operability determination (MP3-004-05) and concluded that the RPCCW HXs were operable but not fully qualified. Engineering's determination was based on recent HX inspections, a structural evaluation of the divider plate (conservatively assuming 35 psid), and a flow and heat transfer analysis (including surveillance testing trends). Engineering also documented their evaluation of OE16319 in CR-05-01767. Engineering determined that the RPCCW HXs would be able to remove the required heat loads during accident events.

Analysis. The inspector considered Dominion's failure to take timely and adequate corrective actions for the degraded RPCCW HX divider plates a performance deficiency since Dominion's corrective action program should correct conditions adverse to quality in a timely manner. Given the repeated nature of the adverse condition (deflected divider plates) and industry OE relative to an in-service failure, the deficiency was reasonably within Dominion's ability to appropriately evaluate and correct prior to February 2005.

The inspector determined that the issue was more than minor because it was associated with the Mitigating Systems cornerstone attribute for equipment performance and potentially affected the objective to ensure the availability and reliability of the RPCCW HXs. The RPCCW system mitigates initiating events as it supplies cooling to the residual heat removal pumps and HXs in the shutdown cooling mode. The degraded RPCCW HX divider plates, if left uncorrected, would result in a more significant safety concern should a divider plate fail catastrophically while in service. The inspector determined the issue to be very low safety significance (Green) using the Phase 1 SDP worksheet for at power situations for the Mitigating Systems cornerstone. This was because the finding was a qualification deficiency confirmed not to result in loss of function. The issue was similarly of very low risk in the Initiating Events

cornerstone because the finding did not increase the likelihood of a reactor trip or a loss of SW event.

The finding was associated with the cross-cutting area of PI&R based on Dominion's inadequate evaluation and untimely corrective actions for this identified deficiency potentially affecting the RPCCW HXs.

Enforcement. Code of Federal Regulations 10 CFR Part 50, Appendix B, "Criterion XVI," Corrective Action, requires, in part, that conditions adverse to quality are promptly identified and corrected. Contrary to this requirement, Dominion failed to take prompt and appropriate corrective actions to address a condition adverse to quality. Specifically, since May 2003, Dominion failed to promptly evaluate and correct a degraded condition associated with the divider plate for all three RPCCW HXs. However, because of the very low safety significance and because the issue was entered into Dominion's corrective action program (CR-05-01281 & CR-05-01767), this finding is being treated as a non-cited violation, consistent with Section VI.A of the Enforcement Policy, issued May 1, 2000 (65FR25368). **(NCV 05000423/2005002-02)**"

DNC Response

DNC denies the violation.

10 CFR 50 Appendix B, Criterion XVI is the NRC standard related to licensee processes supporting resolution of conditions adverse to quality. Criterion XVI stipulates that, "Measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, defective material and equipment, and nonconformances 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. The identification of the significant condition adverse to quality, the cause of the condition, and the corrective action taken shall be documented and reported to appropriate levels of management."

The NCV contends that DNC did not perform an operability assessment related to Reactor Plant Component Cooling Water heat exchanger divider plate deformations experienced at Millstone Power Station Unit 3 (MPS3) upon review of operating experience (OE) identified at the D.C. Cook Station. The NCV also contends that corrective actions to resolve conditions observed at MPS3 were assigned a low priority and therefore not completed in a timely manner. These contentions appear to be based on the NRC's conclusion that MPS3 and D.C. Cook OE are similar and therefore failure of an RPCCW heat exchanger divider plate at MPS3 is likely.

It is Dominion's (DNC) position that an appropriate level of evaluation has been performed in each instance of divider plate deflection noted in the inspection report. Each of those conditions was captured under the Millstone Corrective Action Program, a managed and monitored process whereby degraded and non-conforming conditions are documented and evaluated for potential implications to safety, quality, and operability. Corrective actions to resolve identified deficiencies captured under this program are implemented on a schedule commensurate with the safety significance of the deficiency.

Significant differences exist between MPS3 and D. C. Cook relative to plant specific operating experience (OE) and divider plate design. The nature of these differences is such that a failure similar to that experienced at D. C. Cook is not likely to occur at MPS3. Following DNC's review of the D. C. Cook OE, an appropriate engineering judgment was made as to the safety significance and long-term impact of the conditions observed at MPS3. On the basis of that judgment, a reliability improvement initiative was developed under a DNC approved work management process that requires; 1) two levels of management review, 2) ranking of new initiatives relative to existing projects related to equipment reliability improvement and, on this basis, 3) assigns necessary resources to support resolution.

Additional Information Supporting the Denial

In April 2003, D.C. Cook experienced a hydraulic transient within their service water system. Following the event, Component Cooling Water (CCW) heat exchangers were opened and inspected. In one case, the divider plate was completely torn away on one side of the channel shell and partially torn away on the other. Analysis indicated that the divider plate attachment welds had failed as a result of the overload condition initiated by the hydraulic transient. The failure was facilitated by existing fatigue cracking of the weld. The OE also indicated a history of deflected divider plates and cracked welds.

In each instance noted in the inspection report, the observed heat exchanger divider plate deflections were minor in nature. Each case was evaluated at the time of discovery and, consistent with NRC guidance for degraded and non-conforming condition resolution; the plate configuration was restored to its original configuration prior to returning the affected heat exchanger to service. MPS3 has experienced only one instance of weld cracking. In 1992, two weld cracks were noted for the 'A' heat exchanger divider plate. These welds were repaired and have operated acceptably to this date.

The difference between MPS3 and D. C. Cook weld performance history is attributed to differences in the weld configurations. As identified in the D. C. Cook OE, the weld

configuration employed for their heat exchanger divider plates consisted of a ¼ inch double-sided fillet weld at each end of the divider plate. The MPS3 weld configuration consists of a full penetration weld on three sides of the divider plate (i.e., top and bottom of channel head and at the tube sheet interface) with a ¼ inch fillet weld cover. The channel head cover captures the remaining end of the divider plate in a 3/16 inch deep machined groove.

The information provided in the preceding discussion was developed during the conduct of the original OE review completed by DNC in 2003. This information formed the basis for the responsible engineer's judgment that the conditions observed specific to MPS3 divider plate deflection did not represent a significant condition adverse to quality or pose a short term challenge to operability of the affected heat exchangers.

Relative to timing of actions to the resolve the condition following review of the D. C. Cook OE in 2003, the responsible engineer took appropriate action to develop a reliability improvement initiative to address improvement of the design of the divider plates. That initiative is being managed under the engineering Level Of Effort (LOE) work management process (MP-24-ENG-GDL03). The LOE process can only be utilized after it is first determined that the initiative does not involve restoration or maintenance of equipment functionality or operability. This determination is subject to review by the initiator's supervisor and the Station Equipment Reliability Team working group.

NRC guidance establishes that the evaluation of operability is an ongoing process. During a surveillance test conducted in February 2005, DNC engineers observed that differential pressures across the RPCCW heat exchangers could exceed the design rating (i.e., 23 vs. 20 psi) when two service water pumps were operated in parallel on a single header. Accordingly, a prompt operability determination was made upon identification of this non-conforming condition. The operability determination considered a 35 psi differential pressure across the divider plate and concluded that operation of the as-built heat exchanger would not be challenged at this bounding condition. Thus the divider plates continue to support proper operation of the heat exchangers under all design basis accident conditions with substantial margin.

On the basis of the previous discussion, DNC concludes that the 2003 engineering judgment regarding the potential operability implications of OE related to RPCCW divider plate deflections was sound given the information available at that time, that historical conditions noted for the MPS3 RPCCW divider plates were appropriately resolved consistent with published NRC guidance, and that the long term resolution for this condition is being implemented in a manner that is appropriately reflective of the safety significance of the issue.

Additional Commentary Regarding Characterization of the NCV

NRC Inspection Manual Chapter (MC) 0612, Section 05.03 requires that apparent violations be screened for 'minor issues' using the examples provided in MC 0612 Appendix E. It is DNC's opinion that Appendix E in general sets a threshold condition for classifying violations as more than minor when the condition involves actual consequences affecting safety and/or operability. Given that DNC has documented the basis for its conclusion that the observed condition does not impact operability or safety of operations, and the NRC's apparent acceptance of that conclusion, as such any violation in this instance should not be characterized as more than minor.

It is also DNC's opinion that there are examples in Appendix E that are similar in nature to the conditions described herein that provide further justification for why the observed condition should not be considered more than a minor violation. Specifically;

1. Example 3.g addresses a failure to implement a corrective action for a condition adverse to quality and is considered minor on the basis that there was no safety impact from the associated condition.

2. Example 4.a relates to a failure to document a required evaluation and is considered minor on the basis that the evaluation once documented determined that there was no safety impact.

3. Example 4.d relates to a licensee identified condition which was not in conformance with the FSAR and which was assigned a low priority and thus the licensee failed to take prompt corrective action for a condition adverse to quality. The condition is considered a minor violation because failure to correct the condition did not impact safety.

4. Example 4.f relates to a failed corrective action for a condition adverse to quality associated with a diesel day tank leak that ultimately impinged on other safety related equipment as well. The condition was considered minor on the basis that the condition had no safety or operability impact on the equipment affected.

It is requested that the NRC address DNC's observations related to Appendix E in the final disposition of this matter.

ATTACHMENT 2

DENIAL OF NON-CITED VIOLATION
05000423/2005002-06

MILLSTONE POWER STATION UNIT 3
DOMINION NUCLEAR CONNECTICUT, INC.

Restatement of the NCV

"Introduction. A green non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failure to determine the extent of condition of air found in the RHR discharge piping. Specifically, after discovering and subsequently venting a significant amount of air in the "A" RHR system in May 2004, Dominion did not adequately investigate to determine if air remained in the RHR heat exchanger tubing.

Description. Following the Spring 2004 refueling outage, NRC inspectors questioned why Dominion had found air in the RHR discharge piping. The inspectors determined that the build-up of air in the "A" RHR train occurred when Dominion secured the "A" RHR pump during the reactor coolant system sweep and vent evolution during the Spring outage. Additionally, contrary to procedure requirements, Dominion had decided not to vent the "A" RHR train while coming out of the outage. This issue was dispositioned as an NCV in Inspection Report 05000423/2004007.

Dominion performed a root cause evaluation to determine the cause of the air intrusion and to recommend actions to prevent recurrence. One of the corrective actions that was recommended by the root cause team was to add an RHR suction piping vent valve to the monthly venting surveillance of the system. The root cause evaluation was completed in August 2004 and concluded that there was no air remaining in the RHR system. Subsequently, additional air was found in July 2004 and again in October 2004 during RHR system venting (CR-04-09306) following quarterly RHR pump runs.

The inspectors questioned Dominion as to the source of this additional air discovered in July and again in October 2004. Dominion suspected that the source of air was the "A" RHR heat exchanger and determined that this amount of additional air did not impact "A" RHR pump operability. However, during the subsequent November vent and valve lineup of the "A" train of the RHR system, air was again vented from the suction piping of the "A" RHR pump. Operations determined that this amount of air was excessive, declared the "A" RHR train inoperable, and entered the appropriate limiting condition of operation. Dominion instituted a troubleshooting plan consisting of running the "A" RHR pump several times to strip the air out of the system, performing ultrasonic tests to identify voids, and running full recirculation flow through the "A" RHR heat exchanger. Based on this troubleshooting effort, Dominion confirmed that the source of air was the "A" RHR heat exchanger and was part of the original volume of air first identified in the "A" RHR system following the Spring outage. When the "A" RHR pump was run on recirculation, air was swept out of the "A" RHR heat exchanger and relocated to a horizontal run of pipe at the "A" RHR pump suction. Dominion determined that it would take running the "A" RHR pump approximately 1.5 hours to build up enough air to make the RHR pump inoperable. According to Dominion, the mission time of the RHR pump for a design basis loss of coolant accident (LOCA) is 30 minutes. Dominion evaluated whether the air in the "A" RHR heat exchanger would adversely affect any emergency core cooling system (ECCS) pumps and wrote an operability determination (OD) to

support continued operability of the "A" RHR system. Operations then declared the "A" RHR train operable and exited the associated technical specification.

Analysis. The performance deficiency was the failure to take prompt corrective actions to determine the extent of condition of air that was introduced into the "A" RHR system during the Spring 2004 outage. Dominion's extent-of-condition review did not determine that a significant volume of air remained in the RHR heat exchanger after finding and venting air in the "A" RHR system during subsequent venting evolutions conducted in July and October of 2004. Specifically, Dominion did not recognize the need to expand and accelerate their extent of condition corrective actions following the identification that air remained in the "A" RHR system in July and subsequently again in October of 2004.

This finding was more than minor because it affected the equipment performance attribute and the availability, reliability, and capability objective of this mitigating system. However, subsequent analysis determined that for a large break LOCA, the air would be swept into the core without affecting the RHR pump, and for small break LOCAs, the air would not have affected the operability of the RHR pump within its required mission time, and for all accidents the air would not have migrated to a section of crossover piping that could affect other ECCS equipment. Therefore, this finding, assessed in accordance with NRC Manual Chapter 0609, Appendix A, Attachment 1, "Significance Determination Process for Reactor Inspection Findings for At-Power Situations," was determined to be of very low safety significance (Green) because it did not involve a design or qualification deficiency, represent an actual loss of safety function, or involve seismic, flooding, or severe weather initiating events.

This finding was related to the cross-cutting issue of problem identification and resolution because Dominion failed to perform an adequate extent of condition review to fully evaluate the effect of air that was introduced into the "A" RHR system.

Enforcement. Code of Federal Regulations 10 CFR Part 50 Appendix B, Criterion XVI, "Corrective Action," requires, in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to this requirement, from May to October 2004, Dominion failed to properly assess and correct degradation of the "A" RHR system caused by air introduction during the Spring 2004 refueling outage. Because subsequent evaluation of the air void determined that the system retained operability, the issue was determined to be of very low safety significance and has been addressed by Dominion's CAP (CR 04-10129), this violation is being treated as an NCV, consistent with Section VI.A of the NRC Enforcement Policy. **(NCV 05000423/2005002-06)**"

DNC Response

DNC Denies the Violation.

10 CFR 50 Appendix B, Criterion XVI is the NRC standard related to licensee processes supporting resolution of conditions adverse to quality. Criterion XVI stipulates that, "Measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, defective material and equipment, and nonconformances 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. The identification of the significant condition adverse to quality, the cause of the condition, and the corrective action taken shall be documented and reported to appropriate levels of management."

The NCV contends that gas vented following a July 14, 2004 pump performance test was not addressed by DNC during the conduct of its investigations and thus DNC's understanding of the extent of condition was incomplete when the root cause evaluation (RCE) for CR-04-06166 was documented in August 2004. The NCV further stipulates that on the basis of having failed to adequately assess the extent of condition, a "significant" volume of air was allowed to remain in the 'A' train RHR heat exchanger.

In fact, the DNC Engineering Technical Evaluation (TE) supporting the original investigation of the condition did address the July 14, 2004 pump performance test, and concluded that it was likely that a small volume of air had been swept into the heat exchanger. Additionally, following an extended 'A" RHR pump run in December 2004, DNC conservatively estimated the volume of air potentially trapped in the heat exchanger at one to five standard cubic feet. This volume was not considered significant with respect to the functional performance requirements of the RHR system.

Additional Information Supporting the Denial

Root Cause Evaluation (RCE) CR-04-06166 was performed in response to the identification of air in the 'A' train of the Residual Heat Removal System (RHR) following the spring 2004 refueling outage. The RCE concluded that the air found in the 'A' train of RHR was the result of the train being secured prior to completion of the in-progress Reactor coolant System (RCS) fill, sweep, and venting (FSV) process. As such highly, aerated water was isolated within the system. Operators subsequently deviated from procedures and failed to perform a full flow sweep of the 'A' train to remove excess air.

While the August 2004 RCE concludes all air was removed from the system, this statement was not intended to imply that all dissolved gas had been removed. It is important to note that the RCE is supported by Technical Evaluation (TE) M3-EV-04-0021 which does discuss the likelihood that small amounts of air had been swept into the "A' train RHR heat exchanger during the July 14 pump performance test and that

small volumes of air likely remained in portions of the system which could not be vented under normal operating conditions. The TE also concludes that the heat exchanger was not a significant source of air as flow through the heat exchanger was isolated prior to the introduction of air saturated water during the RCS FSV evolution. The supporting TE also addressed the going forward implications of air remaining in unventable portions of the system as well as the historical safety and operability implications of conditions observed through July 14, 2004. Discussions with the August 2004 RCE lead evaluator indicate that the RCE team considered the implications of the July 14 venting results and concluded those results were consistent with the prevailing gas transport theory of the time and thus did not contradict the root cause. On this basis and given that the TE did discuss the implications of the July 14 venting results, the team elected not to revise the RCE. Furthermore, the progress of the RCE team and the development of the supporting TE were closely monitored by the NRC and it was DNC's understanding that there was general agreement by the NRC with the scope, methodology and conclusions of the RCE team's initial investigations as documented in NRC Integrated Inspection Report 05000336/2004007 and 05000423/2004007 at Section 4OA5.

Following issuance of the August 2004 RCE, ongoing monitoring of system status continued with no air being vented for three successive intervals. Upon identification of air accumulations following the October 2004 quarterly pump performance verification, guidance was provided to operations to support ongoing assessment of operability and the frequency of pump runs was increased to monthly. The threshold value provided by engineering for assessment of operability was exceeded in November 2004 and the system was appropriately declared inoperable. A second RCE (M-2004-10268) was initiated at that time. This RCE was conducted by a different team under different management sponsorship and included a critical evaluation of previous investigation activities. While this report identified several opportunities where more investigation could have yielded greater understanding of the status of air remaining in the 'A' train of RHR, it did not identify a fundamental flaw with any particular decision made during the original evaluation.

As previously discussed, Technical Evaluation M3-EV-04-0021 was initially issued in support of RCE CR-04-06166 and acknowledges the potential for small amounts of air to have been swept into the 'A" train RHR heat exchanger during the July 14, 2004 pump run. This TE was revised following the identification of air in October 2004 to include additional conservative guidance for ongoing operability assessment. This TE was again revised in February 2005 to address the cumulative impact to safety and operability of gas accumulations vented through November 2004.

The February 2005 revision of the TE discusses the phenomena supporting the theory that gas was being transported from the heat exchanger into the flow stream when the 'A' RHR pump was being run on recirculation. It should be noted that there is no precise way to validate the existence of air in the heat exchanger. The volume of air

potentially isolated within the heat exchanger was conservatively estimated to be between one and five standard cubic feet (DNC Memo NUCENG-04-121). This amount is not considered significant in the context of system reliability or operability.

In January and February of 2005, DNC conducted high flow sweeps of the 'A' train RHR system to remove residual accumulations of air. Water was drawn from the Refueling Water Storage Tank (RWST) and circulated at high flow rates through accessible portions of the piping system back to the RWST. Following these high flow sweeps of the "A" train RHR system, air continues to accumulate at the system high points following pump performance tests. This is likely due to the fact that the RWST is vented to atmosphere and the contents of this tank are gas saturated for those conditions. As discussed in the February revision of TE M3-EV-04-0021, gas stripping will occur downstream of the minimum flow recirculation flow control valve due to the significant pressure drop (i.e., 212 psig to 33 psig) across this two inch valve.

Additional Commentary Regarding Characterization of the NCV

NRC Inspection Manual Chapter (MC) 0612, Section 05.03 requires that apparent violations be screened for 'minor issues' using the examples provided in MC 0612 Appendix E. It is DNC's opinion that Appendix E in general sets a threshold condition for classifying violations as more than minor when the condition involves actual consequences affecting safety and/or operability. Given that DNC has documented the basis for its conclusion that the observed condition does not impact operability or safety of operations, and the NRC's apparent acceptance of that conclusion, it is DNC's opinion that any violation in this instance should not be characterized as more than minor.

It is also DNC's opinion that there are examples in Appendix E that are similar in nature to the conditions described herein that provide further justification for why the observed condition should not be considered more than a minor violation. Specifically;

1. Example 3.g addresses a failure to implement a corrective action for a condition adverse to quality and is considered minor on the basis that there was no safety impact from the associated condition.

2. Example 4.a relates to a failure to document a required evaluation and is considered minor on the basis that the evaluation once documented determined that there was no safety impact.

3. Example 4.d relates to a licensee identified condition which was not in conformance with the FSAR and which was assigned a low priority and thus the licensee failed to take prompt corrective action for a condition adverse to quality. The condition is considered a minor violation because failure to correct the condition did not impact safety.

4. Example 4.f relates to a failed corrective action for a condition adverse to quality associated with a diesel day tank leak that ultimately impinged on other safety related equipment as well. The condition was considered minor on the basis that the condition had no safety or operability impact on the equipment affected.

It is requested that the NRC address DNC's observations related to Appendix E in the final disposition of this matter.