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SUBJECT: Forwards commitment change summary rept for DCPP Units 1 & 2,providing summary of regulatory commitment changes that occurred during period of 980101 through 990616.

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June 14, 1999

PG&E Letter DCL-99-080

U.S. Nuclear Regulatory Commission
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Docket No. 50-275, OL-DPR-80
Docket No. 50-323, OL-DPR-82
Diablo Canyon Units 1 and 2
Commitment Change Summary Report

Dear Commissioners and Staff:

In accordance with the Nuclear Energy Institute's (NEI) "Guideline for Managing NRC Commitments," Revision 2, endorsed by the NRC in SECY-95-300, PG&E hereby submits the enclosed Commitment Change Summary Report for Diablo Canyon Power Plant, Units 1 and 2. The report provides a summary of the regulatory commitment changes that occurred during the period January 1, 1998, through June 16, 1999. The summary for each change includes identification of the source document(s), a description of the original and revised commitments, and a justification for the change.

The regulatory commitment changes described in the report were processed in accordance with the NEI guideline, and were determined to not require prior NRC approval. The report does not include commitment changes that are contained in 10 CFR 50.59 safety evaluation summary reports, or in other submittals previously transmitted to the NRC.

Sincerely,

Gregory M. Rueger

cc: Steven D. Bloom
Ellis W. Merschoff
David L. Proulx
Diablo Distribution

Enclosure

WEC/1392/A0463582

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JANUARY 1, 1998 THROUGH JUNE 14, 1999

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1. Strip Chart Recorder Daily Time Strikes

Source Document(s): PG&E Letter DCL-86-082, "Response to IEIR 50-275/85-41 and 50-323/85-39 -- Notice of Violation" dated March 25, 1986

Original Commitment

AP C-152 (Recording Charts) will be (has been) revised to specify which strip chart recorders are required to be time struck daily.

Revised Commitment

None. The commitment has been deleted.

Justification for Change

Because most information from chart recorders is captured and archived by the plant process computer (PPC), PG&E believes there is no need to time strike chart recorders. Additionally, because plant "events" are infrequent, it is sufficient to time strike charts when trips, transients, or anomalies occur. Additionally, the change improves the process by eliminating the potential for personnel error to follow procedures since the PPC is relied upon for recording and archiving data from the various chart recorders.

2. C&RP Foreman Shift Turnover Checklist Review

Source Document(s): PG&E Letter DCL-86-100, Licensee Event Report (LER) 2-86-009-01, "Missed Surveillance Due to Technician Failing to Change Plant Vent Sample Media," dated April 14, 1986

Original Commitment

A revision to procedure AP C-201S1, "Chemistry and Radiochemistry Data Review and Record Management," will require the C&RP foreman to review all shift turnover checklists (daily) to ensure compliance with surveillance requirements T.S. 4.11.2.1.2. [The "daily" descriptor was mentioned in the abstract to the LER, not in the Corrective Actions section.]

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Revised Commitment

The oncoming shift technician will review the turnover checklist to verify that the checklist has been properly completed and that appropriate actions were carried out. The chemistry foremen still perform their reviews, but the reviews may not be on a "daily" basis.

Justification for Change

The intent of the commitment has been preserved by having the oncoming shift technician review the chemistry shift turnover checklist for accuracy. As stated in the revised commitment, the chemistry foremen will still review the checklists, but not necessarily on a daily basis (e.g., on weekends, holidays, etc.)

3. Component Cooling Water Heat Exchanger Cleaning During Each Refueling Cycle

Source Document(s): PG&E Letter DCL-94-037, "Auxiliary Saltwater System Operability," dated February 15, 1994

Original Commitment

In accordance with Maintenance Procedure MP M-56.16, "Heat Exchanger Tube Cleaning," the heat exchanger tubes are mechanically scraped during each refueling outage (nominally every 18 months).

Revised Commitment

In accordance with Maintenance Procedure MP M-56.16, "Heat Exchanger Tube Cleaning," the heat exchanger tubes are mechanically scraped during each refueling outage (nominally every 24 months).

Justification for Change

The time between component cooling water (CCW) heat exchanger (HX) tube scraping has been extended to 24 months in anticipation that refueling cycles could be extended to that duration. By extending the interval to 24 months there is a potential that the HX will undergo additional fouling. Fouling can be due to biofouling, debris accumulation, siltation, or deposition. Each of these mechanisms is addressed as follows:

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A. Biofouling has not been noted since implementation of continuous chlorination. Through continuous injection of sodium hypochlorite solution, the auxiliary saltwater (ASW) pipe and the CCW HXs are maintained free of slime or other life that could cause an insulating film to form on the HX tubes. PG&E's 6-month biofouling inspections have shown no signs of biofilm since continuous chlorination was implemented. Lengthening the cycle will not make the HX more vulnerable to biofouling.

B. Debris accumulation on the inlet tubesheet is indicated in the control room as a rising differential pressure (d/p) across the CCW HX. A limit for cleaning the HX is provided in Surveillance Test Procedure (STP) I-1A, "Routine Shift Checks Required by Licenses." A longer cycle will not impact PG&E's ability to diagnose or respond to an elevated d/p.

C. Since the CCW HXs operate at design flow whenever they are in service, PG&E has never noted any accumulation of silt or sediment. This is because the HX flow rate is great enough to prevent silt from accumulating in the waterboxes or in the tubes. A longer cycle will not precipitate an increase in accumulation of sediment.

D. The major deposition mechanism in the CCW HXs is calcium carbonate deposited on the tube outlets on the Unit 2 CCW HXs. Due to a slightly different configuration, Unit 1 is not subject to this phenomenon. When the Unit 2 CCW HXs are taken out of service, the saltwater side remains partially full. Due to the position of the cathodic protection system reference and protection anodes, this causes the cathodic protection current to be maximized, which causes the deposition of carbonate. This deposition has been greatly reduced by a change to the Operating Procedure E-5:IV, "Auxiliary Saltwater System - Changing Over Pump and Heat Exchanger Trains," which now requires operators to vent the Unit 2 CCW HXs allowing water to drain from the saltwater side. As additional assurance, should deposition occur, it could be detected by an increase in the d/p which is monitored in the control room.

E. There has been slight deposition of a brown material throughout the ASW system. This consists of minerals precipitated from seawater by the chlorine injection.

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F. HX testing after 20 months of operation yielded results similar to those obtained after 18 months, to within experimental uncertainty. This demonstrates that the cycle length increase does not impact CCW HX performance.

4. Postcalibration Check Prior to Test of Main Steam Safety Valve on Same Steamline

Source Document(s): PG&E Letter DCL-91-309, LER 2-91-002-00 (Voluntary), "Potential Missetting of Main Steam Line Code Safety Valve due to Failure of Test Equipment," dated December 20, 1991

Original Commitment

Maintenance Procedure MP M-4.18, "Verification of Lift Point Using Furmanite's Trevitest Equipment for the Main Steam Safety Valves," was revised to require a post calibration check of the Trevitest equipment prior to testing another MSSV on the same steamline.

Revised Commitment

None. The commitment has been deleted.

Justification for Change

This corrective action is no longer required. The Furmantite Trevitest equipment has been significantly upgraded since 1991 with a much higher reliability. Experience with this upgraded equipment has evidenced no failures of any kind in calibration while in service. The recorder which experienced the low battery failure is no longer battery powered, but rather powered by 120V ac.

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5. Security Computer System Failure

Source Document(s): PG&E Letter DCL-97-109, LER 1-97-S02-00, "Security Computer System Failure Due to the Apparent Failure of the Computer Disk Drive Without Implementing Full Compensatory Measures Within 10 Minutes," dated June 6, 1997

PG&E Letter DCL-98-029, LER 1-98-S02-00, "Following Security Computer System Failure, Full Compensatory Measures Not Implemented Within 10 Minutes Due to Personnel Error," dated February 26,1998

Original Commitment

A preventative maintenance changeout of security computer disk drives has been established to lessen the probability of a future similar failure.

Revised Commitment

None. Commitment has been deleted. In LER 1-98-S02-00, PG&E indicated that, if necessary, the corrective actions described in LER 1-97-S02 would be revised. The review of those corrective actions resulted in the deletion of this commitment.

Justification for Change

As discussed in LER 1-98-S02-00, PG&E believes that the cause of a security computer disk drive failure on January 13, 1998, was maintenance induced. Further, preventative maintenance to routinely replace disk drives is believed to be a contributory cause. Whenever an operating electronic component is replaced, there is an increased risk of disk failure in the near future. Electronic components have a higher probability of failure when they are disturbed. Therefore, a preventative maintenance change-out of security computer disk drives will no longer be practiced.

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6. Human Performance Evaluation System Evaluation

Source Document(s):

PG&E Letter DCL-87-136, "PG&E Management Actions to Maintain the High Level of Performance at DCPP," dated June 15, 1987

PG&E Letter DCL-89-006, "Additional Information Re: Reply to Notice of Violation in NRC Inspection Report Nos. 50-275/88-15 and 50-323/88-14," dated January 6, 1989

Original Commitment

The INPO Human Performance Evaluation System evaluation techniques will be used by the TRG to ensure evaluations effectively identify root cause and determine corrective actions.

Revised Commitment

None. Commitment has been deleted.

Justification for Change

The human performance evaluation system reporting system is no longer supported by INPO, nor is it routinely used by any plants, including DCPP. Methods for the detection, evaluation, and resolution of human performance problems has progressed significantly since the HPES was conceived in 1986. Recent evaluations have demonstrated that PG&E's current Corrective Action Program adequately addresses human performance, process, and organizational causes. This program conforms to INPO Good Practices OE-907, "Root Cause Analysis" (INPO 90-004).

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7. Verification of Lifted Leads and Jumpers

Source Document(s): NRC Inspection Report Nos. 50-275/86-13 and 50-323/86-14, dated June 3, 1986

Original Commitment

This procedure (Electrical Field Instruction ETI-2-1) was to be revised (has since been revised) to include the provision for QC involvement and independent verification of lifted leads and jumpers.

Revised Commitment

None. The commitment has been deleted.

Justification for Change

The construction organization startup department which issued the procedure no longer exists and the procedure was deleted. Plant administrative procedures now ensure lead and jumper lifting and landing are appropriately verified.

8. Audit Response - Nonsignificant Findings

Source Document(s): PG&E Letter DCL-84-131, "Response to Board Notification 84-071," dated April 4, 1984.

Original Commitment (Paraphrased)

Audit findings are considered not "significant" (as indicated in 10 CFR 50, Appendix B, Criterion XVI), if they are not identified on an NCR nor documented on an Audit Finding Form. However, the evaluation for generic implications (shall) take place and (shall) be a basic part of the review of all audit findings. A revision of QA procedures {shall} require the audited organization to document its investigation into each finding to determine the cause, the measures to prevent recurrence, and the generic implications.

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Revised Commitment.

Audit findings are considered not "significant" (as indicated in 10 CFR 50, Appendix B, Criterion XVI), if they are not identified on an NCR (nonconformance report) nor documented on an Audit Finding Form. However, the evaluation for generic implications shall take place and shall be a basic part of the review of all audit findings.

Justification for Change

The old commitment required the audited organization to: " ...document its investigation into each finding to determine the cause, the measures to prevent recurrence, and the generic implications," regardless of the level of significance the problem identified in the audit finding. The regulatory requirements which address determination of cause do not require that an analysis be done for problems that are not significant. PG&E believes the new statement of commitment removes an unnecessary burden from the audited organization and is consistent with regulatory requirements.

9. Resolution of Questions Regarding Operability of the Auxiliary Saltwater System

Source Document(s): PG&E Letter DCL-94-037, "Auxiliary Saltwater System Operability," dated February 15, 1994.

Original Commitment

PG&E has established an Interdepartmental Administrative Procedure to resolve issues that raise questions regarding operability. The key elements will be:

A. Address any issue of immediate operability concern using OM7.ID8.

B. Generate a Quality Evaluation (QE) for issues that are not a clear, immediate operability concern, if the issue remains unresolved for 30 days.

C. Establish firm completion dates within the QE.

D. Place issues exceeding these completion dates on an "Operability Concerns List."

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E. Review the Operability Concerns List at the NPG Officers/Managers weekly meeting.

F. Assign specific responsibilities for resolution of Operability Concerns List items at the weekly meeting.

G. Review progress on assigned issues as identified by the Manager of Nuclear Quality Services.

Revised Commitment

PG&E will establish an Interdepartmental Administrative Procedure (IDAP) to resolve issues that raise questions regarding operability. The key elements will be:

A. Timely and thorough assessments of degraded or non-conforming conditions which may impact operability, or conditions that may place operability into question.

B. Additional management and technical review for operability evaluations of degraded or nonconforming conditions, commensurate with the safety significance of the issue.

C. Management oversight, review and tracking of identified concerns which lack objective evidence or information that a degraded or non-conforming condition exists (issues needing validation to determine impact on operability-INVDIO) to ensure appropriate and timely resolution, commensurate with potential significance.

D. Appropriate notifications when progress in resolving INVDIO issues is not considered timely.

Justification for Change

A. PG&E has converted procedure numbers and has improved upon its program for resolving issues that raise operability concerns. Specifically:

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1) Degraded or nonconforming conditions which may impact operability, or conditions that may place operability into question, are evaluated using IDAP OM7.ID12, "Operability Determination." The determination of operability is completed within 24 hours.
2) Degraded or nonconforming conditions which have the potential for significant adverse safety consequences or have regulatory significance which may warrant additional technical and management review are evaluated using IDAP OM7.ID8, "Operability Evaluation." The time evaluation is commensurate with the safety significance of the issue. Operability evaluations may be generated as the initial basis for operability or as a follow-up to an operability determination made in accordance with OM7.ID12.
3) Identified concerns which lack objective evidence or information that a degraded or nonconforming condition exists are evaluated using IDAP OM7.ID5, "Issues Needing Validation to Determine Impact on Operability (INVDIO)." The time of evaluation is commensurate with the potential safety significance of the issue. Due dates for completion which exceed 30 days must be approved by the department manager for the organization responsible for resolving the INVDIO.
4) INVDIO issues are tacked on an INVDIO Issue List which is maintained by the AR Review Team (ARRT). This list is reviewed by the ARRT each week (the ARRT review will be captured in OM7.ID5).
5) The AART notifies the manager responsible for resolving the INVDIO when progress is not considered timely and to assure appropriate actions are being taken. This will be captured in OM7.ID5.
6) The ARRT notifies the manager of NQS if INVDIO resolution progress is not considered timely. The NQS manager determines of the issue warrants further review with the NPG Management Team.
7) The IDAP for problem identification and problem resolution (OM7.ID1, "Problem Identification and Resolution - Action Requests") clearly integrates operability considerations in both the responsibilities section and work in progress instructions.

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8) Corrective Maintenance (CM) and Administrative Task (AT) Action Requests are reviewed daily by AART which is composed of five qualified members, including a chairman, selected and approved by the NPG Leadership Team. The ARRT evaluates all problems for significance and ensures immediate actions are initiated as required (OM7.ID1).

B. Management involvement and oversight in the resolution of operability issues is significant, integrated, and specifically required in operability evaluation work process controls contained in the aforementioned IDAPs.

C. INVDIO Quality Evaluations (QE) no longer provide any benefit relative to improving or tracking timely resolution of INVDIO issues. The original intent for generating a QE is now satisfied by OM7.ID5 and OM7.ID1 which ensures that INVDIO issues are appropriately identified, tracked, and resolved in a timely manner commensurate with problem significance.

10. Root Cause Analysis Requirements

Source Document(s): PG&E Letter DCL-88-236, "Reply to Notice of Violation in NRC Inspection Report Nos. 50-275/88-15 and 50-323/88-14," dated October 5, 1988

NRC Inspection Report Nos. 50-275/89-21 and 50-323/89-21, dated September 29, 1989

Original Commitment

Because of its failure to adequately determine the cause of a number of events for which it received an NOV, PG&E made the following commitments in its October 5, 1988 reply:

A. Administrative Procedure C-12, "Investigation and Resolution of Problems and Nonconformances," has been revised to require performance of a root cause analysis on quality evaluations except those on minor non-repetitive equipment problems that do not have generic implications. Quality control department concurrence is required on quality-related (quality evaluations) QEs, including those having root cause determination.

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B. On September 15, 1998, DCPP personnel were informed by plant management in a memorandum that QEs should be initiated for significant balance of plant problems that warrant a root cause analysis. These problems include unexpected events or equipment malfunctions that are likely to result in one of the following if the root cause is not identified or corrected:

1) Plant trip or curtailment of more than 20 MW
2) Significant primary system transient
3) Challenge to a safety system
4) Significant equipment damage
5) Violation of NPDES permit
6) Personnel injury

C. Administrative Procedure C-12 was revised to incorporate the (aforementioned) September 15, 1988, guidance to require that QEs or NCRs (nonconformance reports) be written to document and resolve nonsafety-related problems that are significant enough to need a root cause determination.

D. All General Construction startup personnel have been instructed that (action requests) ARs, not Action Evaluations, need to be written to document problems. General Construction has adopted the DCPP problem reporting system of ARs and QEs. This is reflected in General Construction Procedure PI-12, revision 5, which was effective October 1, 1988.

In the NRC's September 29, 1989, Inspection Report 50-275/89-21 and 50-323/89-21, the NRC noted the following statement of commitment:

E. During a meeting with NRC Inspectors on April 22, 1988, the Plant Manager committed to the development of an action plan which would address criteria to be incorporated in revised or new administrative procedures to lower the threshold for events to be subjected to formal root cause determination. Specific consideration was to be given to revising applicable procedures to require formal root cause determination in the dispositioning of Quality Evaluations (QE) reports, of which there are approximately 660 per year at that time.

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Revised Commitment

Administrative Procedures (IDAPs) provide specific requirements for problem identification and resolution. These procedures include corrective action program elements which:

A. Provide specific criteria for what constitutes a problem and when problems are to be resolved on Action Requests (ARs), Quality Evaluations (QEs), and Nonconformance Reports (NCRs).

B. Provide specific criteria for when a Nonconformance Report (NCR) must be used to resolve problems.

C. Require a formal cause analysis for problems which are being resolved on QEs or NCRs, regardless of the classification of the system.

D. Implement management oversight and review problems such that the appropriate level of problem resolution (AR, QE, or NCR), commensurate with problem significance, is used.

E. Require a QE for any problem which does not meet the criteria for an NCR and for which a management AR review process has determined that a QE and a formal cause analysis is warranted.

F. Require Nuclear Quality Services concurrence with the cause determination and the corrective actions to prevent recurrence for all quality related QEs.

Justification for Change

The primary reasons for the change are: 1) to eliminate the requirement to initiate a QE for balance-of-plant (BOP) problems as described in item B of the above original commitment, and 2) to reflect the improved requirements and current practices for resolving significant BOP problems. More specifically:

A. Reference to the General Construction organization has been deleted as this organization no longer exists at Diablo Canyon Power Plant.

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B. The existing commitment statements did not appropriately reflect management's new role in reviewing ARs for problem significance and assignment of the quality problem classification (i.e., quality problem AR, QE, or NCR).

C. The problem criteria for ARs, QEs, and NCRs are very specifically identified in administrative procedures. All NCRs and QEs require a formal cause analysis.

D. The Diablo Canyon letter included certain BOP problem criteria which warranted a formal cause analysis. These criteria were specified at a time when the problem reporting and resolution process was not as well defined and implemented an in the current state.

E. Problems documented on ARs are now reviewed by a management appointed team (ARRT) which is composed of five qualified members, including a chairman, selected and approved by the NPG Leadership Team. As a minimum, this team is currently comprised of the Chairman and representatives from Operations Services, Maintenance Services, Nuclear Technical Services, and Nuclear Quality Services.

F. The specific criteria delineated in the original commitment as item 2 above are utilized by the ARRT when determining the need for a QE.

G. The criteria for NCRs provided in INPO Good Practice 90-004, "Root Cause Analysis," January 1990, are retained in the criteria used to determine when a problem is to be resolved using an NCR.

11. Revision of Procedure MP E-63.1A to Preclude Inadvertent Diesel Generator Autostart

Source Document(s): PG&E Letter DCL-88-194, "LER 2-88-007-00, "Autostart of Diesel Generator 2-1 Due to Inadvertent Removal of Vital Bus Potential Fuse Block During Preventive Maintenance," dated August 1, 1988.

Original Commitments

Maintenance Procedure E-63.1A will be revised to add caution statements regarding removal of wrong fuses.

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Revised Commitment

None - This commitment has been deleted.

Justification for Change

Red lamocoid signs on the fuse holders inside the breaker cubicle now provide adequate caution to craftsmen to preclude recurrence of the event. In addition, as described in PG&E Letter DCL-97-101, LER 1-97-009, "Unplanned Start and Load of Diesel Generator 1-1 (ESF Actuation) Due to Personnel Error and Inadequate Work Controls," dated June 6, 1997, component information identifying the unique CCW cubicle design was added to the plant information management system (PIMS). The information alerts those planning and scheduling work and clearing equipment that the cubicle contains electrical components for the bus which may require special planning, work, and clearance controls. A precautionary note was also added to applicable drawings. The note alerts personnel involved in the work process that the CCW cubicles contain electrical equipment for the bus. An inadvertent start of the diesel generators for the same cause identified in the LER has not reoccurred.

12. Caution Statement in Work Order to Preclude Inadvertent Diesel Generator Autostart

Source Document(s): PG&E Letter DCL-88-194, LER 2-88-007-00, "Autostart of Diesel Generator 2-1 Due to Inadvertent Removal of Vital Bus Potential Fuse Block During Preventive Maintenance," dated August 1, 1988.

Original Commitment

A caution will be added to the Work Planning Center library copy of planned maintenance work orders.

Revised Commitment

None - This commitment has been deleted.

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Justification for Change

Red lamocoid signs on the fuse holders inside the breaker cubicle provide adequate caution to the craftsmen to preclude recurrence of the event. In addition, as described in the LER 1-97-009, component information identifying the unique CCW cubicle design was added to PIMS. The information alerts those planning and scheduling work and clearing equipment that the cubicle contains electrical components for the bus which may require special planning, work, and clearance controls. A precautionary note was also added to applicable drawings. The note alerts personnel involved in the work process that the CCW cubicles contain electrical equipment for the bus. An inadvertent start of the diesel generators for the same cause identified in the LER has not reoccurred.

13. Control of Work Activities on Doors

Source Document(s): PG&E Letter DCL-91-072, "Reply to Notice of Deviation," dated April 1, 1991

PG&E Letter DCL-91-157, LER 2-90-002-02, "Fuel Handling Building Ventilation System Inoperable During Fuel Movement Due to Personnel Error," dated June 18, 1991

Original Commitment

An administrative procedure was developed to control plant doors important to safety.

Revised Commitment

None - This commitment has been deleted.

Justification for Change

In 1990, as a result of a hose blocking open a fuel handling building (FHB) door, the FHB ventilation system was found to be inoperable during the movement of fuel. In addition, during maintenance activities in 1991, personnel removed a door sign which identified the door as a ventilation boundary for the FHB and failed to reattach it upon completion of the work. This contributed to leaving the door open for a prolonged period of time and to the failure to maintain the

required ventilation conditions during fuel movement activities. As a result of these incidents, PG&E committed to establish an administrative procedure for the control of plant doors important to safety. The administrative procedure was subsequently generated to satisfy this commitment.

PG&E now recognizes there are other measures which ensure that plant doors important to safety are administratively controlled. These measures include:

A. Generation of Equipment Control Guideline (ECG) 80.1, "Doors Required for HELB, HVAC, or Flood Protection," and ECG 18.7, "Fire Rated Assemblies."

B. Administrative Procedure OM8.ID2, "Fire System Impairment"

C. Revised general employee training

D. The requirement that the shift foreman (SFM) be notified when a door is found in an impaired condition (e.g., latch damage, closure mechanism damaged, etc.) or when planned impairments are scheduled.

Since sufficient checks are in place to ensure that impaired doors are identified and repaired expeditiously and that doors are not left open without notification and approval of the SFM, the commitment has been deleted.

14. Acoustic Monitoring of Turbine Stop Valves

Source Document(s): PG&E Letter DCL-93-218, LER 2-92-003-02, "Unit Shutdown Required Due to Inoperable High Pressure Turbine Stop Valve," dated September 7, 1993

Original Commitment

An interim acoustic monitoring program has been established in conjunction with Westinghouse lessons learned, to monitor the stop valves until confidence in the valve integrity has been reestablished.

Revised Commitment

None - This commitment to be deleted.

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Justification for Change

In 1992, DCPP experienced a mechanical failure of a turbine stop valve. As part of the LER corrective actions, the acoustic monitoring system for the stop valves was installed to monitor the condition of the valve internals during and in addition to routine valve stroking testing.

As stated in the above commitment, DCPP installed and utilized the acoustic monitoring system for 6 years. The results of the surveillance testing and review of the acoustic data indicated neither mechanical nor valve internal failures. During this period, DCPP also participated in a Westinghouse Owner's Subgroup, which was chartered to monitor the failure rates of the Westinghouse turbine valves throughout its fleet. As reported in a recent Westinghouse report (WOG-TVTF-98-012), the valve failure rating has been decreasing.

DCPP has demonstrated, through its own surveillance testing and review of industry experience, acceptable level of performance and confidence in turbine stop valve integrity.

15. Quarterly Stroke Testing of Air Dump Valves and Response Check

Source Document(s): PG&E Letter DCL-91-033, LER 1-89-009-01, "Reactor Trip and Safety Injection From Steam Line Differential Pressure Spurious Signals," dated February 21, 1991

Original Commitment

Surveillance Test Procedure (STP) V-3R1, "Exercising 10 Percent Atmospheric Dump Valves PCV-19 & 20 & 21 & 22" was revised to stroke the ADVs quarterly. The revision added detail to check for proper valve response to manual controller inputs.

Revised Commitment

Surveillance Test Procedure (STP) V-3R1, "Exercising 10 Percent Atmospheric Dump Valves PCV-19 & 20 & 21 & 22" was revised to stroke the ADVs quarterly.

COMMITMENT CHANGE SUMMARY REPORT
JANUARY 1, 1998 THROUGH JUNE 14, 1999

Justification for Change

PG&E made the original commitment as part of its corrective action in response to the Unit 1 automatic safety injection and reactor trip that occurred on October 6, 1989. The reasons for modification of the original corrective action commitments are as follows:

A. This valve response data (stem travel vs. demand) is not considered as part of the valve operability acceptance criteria.

B. The additional manpower and out of service time (unavailability) required to collect this data during STP V-3R1 does not add any significant value to the reliability of the air dump valves.

16. Notification and Review of Fire System Impairments

Source Document(s): PG&E Letter DCL-96-068, LER 1-84-048-00, "Technical Specification 6.8.1.h Not Met Due to a Programmatic Deficiency," dated March 22, 1996.

Original Commitment

Administrative Procedure OM8.ID2 requires the shift foreman and the fire protection specialist to be informed immediately of any discovered fire system impairment and to review any planned fire system impairment.

Revised Commitment

Administrative Procedure OM8.ID2 requires the shift foreman and the fire protection specialist to be informed immediately of any discovered fire system impairment and to review any planned fire system impairment. However, for maintenance activities associated with doors, no review by fire protection is required.

Justification for Change

Since the conception of this commitment, fire protection has been reviewing work orders (W/Os) for maintenance activities for doors (replacement/adjustment of closure mechanism, replacement of latch, painting of doors, etc.). For the last several months, fire protection has noted that for those W/Os associated with door maintenance, adequate inspection criteria has been specified to ensure

doors are tested in accordance with STP M-70C, "Door Inspection Instructions and Maintenance Requirements. With this established history, and procedural changes made in Maintenance Procedure M-56.11, "Door Inspection Instructions and Maintenance Requirements," that require an STP M-70C inspection after door maintenance, PG&E does not feel that fire potection needs to oversee the review of W/Os associated with maintenance activities on doors. The review had become a burden on both the maintenance and fire protection organizations, and the review no longer served a vital function.