



CHARLES CENTER • P. O. BOX 1475 • BALTIMORE, MARYLAND 21203

ARTHUR E. LUNDVALL, JR.
VICE PRESIDENT
SUPPLY

April 25, 1984

U. S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

Docket Nos. 50-317
50-318
License Nos. DPR-53
DPR-69

ATTENTION: Mr. R. W. Starostecki, Director
Division of Project & Resident
Programs

Gentlemen:

This refers to Inspection Report 50-317/84-03, 50-318/84-03; which transmitted two items of apparent noncompliance with NRC requirements. Enclosure (1) to this letter is a written statement in reply to those items noted in your letter of March 26, 1984.

Should you have further questions regarding this reply, we will be pleased to discuss them with you.

Very truly yours,

AEL/LOW/tlm

Enclosure

cc: D. A. Brune, Esquire
G. F. Trowbridge, Esquire
D. H. Jaffe, NRC
T. Foley, NRC

8406050285 840530
PDR ADOCK 05000317
G PDR

ENCLOSURE (1)

REPLY TO APPENDIX A OF NRC INSPECTION REPORT 50-317/84-03; 50-318/84-03

ITEM A.1

An apparent violation was identified involving failure to properly implement safety tagging of the Oxygen Analyzer System. The major contributing cause that led to the February 15, 1984, violation was failure of tagging personnel to properly identify the valves that were tagged. The following actions have been taken to ensure that similar violations will not recur in the future.

Commencing on March 1, 1984, all personnel who are designated to perform mechanical safety tagging must demonstrate proficiency as a mechanical tagger by completing a recently developed qualification program. The major elements of this program include classroom instruction on the precautions and guidance contained in Calvert Cliffs Instruction-112, Safety Tagging, followed by a written test and a practical demonstration of knowledge.

One improper practice that contributed to the February 15, 1984, violation involved failure of personnel to carry adequate information into the field to assist in identifying the valves to be tagged. Effective as of March 1, 1984, all safety tagging personnel have been instructed to carry a copy of the tagout record, which contains a complete functional description of each valve to be tagged into the field.

The General Supervisor-Operations has instructed the Operating Staff to use only those individuals who have been qualified to perform safety tag outs for tagging jobs. Only in emergency situations where time is critical will this order be relaxed, otherwise, qualified tagging personnel will be called in to support backshift and weekend activities.

ITEM A.2

An apparent violation was identified involving failure to properly review the status of operability of the service water supply to #21 diesel generator during realignment of the service water and salt water systems to support maintenance on an ECCS Pump Air Cooler saltwater strainer.

The service water system cross-connect between #21 and #22 service water subsystems is located downstream of valves which receive an automatic closure Safety Injection Actuation Signal following a loss of coolant accident. Therefore, with #22 service water subsystem out-of-service, cooling water would be lost to two containment coolers as well as #21 diesel generator. We would like to point out, that in recognition of this fact, Operating Procedures were revised in 1983 which requires lining up the containment coolers to receive service water from the alternate subsystem whenever either service water subsystem is removed from service. Although no engineering evaluation was performed at the time to support the assumption, it was assumed that opening the eight-inch manual cross-connect valves would in addition provide continued availability of cooling water to #21 diesel generator. Accordingly, #21 diesel generator was not considered inoperable when #22 service water subsystem was removed from service on March 6, 1984, to perform maintenance on #22 salt water system supply to the ECCS Pump Room Coolers.

ENCLOSURE (1)

**REPLY TO APPENDIX A OF NRC INSPECTION
REPORT 50-317/84-03; 50-318/84-03**

Notwithstanding the aforementioned circumstances to ensure operability of #21 diesel generator, all Operations personnel were instructed on March 9, 1984, by the General Supervisor-Operations to consider #21 diesel generator inoperable whenever #22 service water subsystem is removed from service. A note to this effect was added to the Operating Instruction which is used to remove #22 service water subsystem from service.

To ensure that similar questions will not arise in the future regarding diesel generator operability, the previously outlined actions will remain in effect until completion of an engineering evaluation to assess the feasibility of supplying service water to #21 diesel generator via the containment cooler cross-connect and/or Unit 1 service water system.