



Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038

Nuclear Department

July 13, 1984

Regional Administrator, Region 1
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Attention: Mr. Richard W. Starostecki, Director
Division of Project and Resident Programs

Dear Mr. Starostecki:

NRC COMBINED INSPECTION 50-272/84-15 AND 50-311/84-15
SALEM GENERATING STATION
UNITS NO. 1 AND 2
DOCKET NOS. 50-272 AND 50-311

During the subject inspection conducted on April 12 to May 8, 1984, three violations were observed involving failure to follow procedures for feedwater system cleanup strainer operation and review of reactor trips, failure to take corrective action to ensure restoration of rod position indication and timely testing of diesel generators following a loss of 2B vital bus, and failure to develop a complete and accurate Master Equipment List (MEL) based on observed misclassifications. The following are PSE&G's responses to this Notice of Violation.

NOTICE OF VIOLATION

Item A

Technical Specification 6.8.1.a requires that written procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978 be implemented.

1. Integrated Operating Procedure (IOP) 8, Maintaining Hot Standby (HSB), Revision 1, requires that Operating Instruction (OI) III.9.3.4, Placing the Condensate System in Service for Cleanup, Revision 0, be carried out if the plant will remain in HSB for more than three hours. OI III.9.3.4 requires that valves 21-24BF13 be closed.

The Energy People
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Contrary To The Above:

21-24BF13 were not closed during the period between a unit trip at 9:17 a.m. on April 6, 1984 and a water hammer event which occurred while stroke testing feedwater regulating valve 23BF19 at 4:33 p.m. on April 6, 1984 with the unit in HSB.

2. Administrative Directive (AD) 16, Post Reactor Trip/Safety Injection Review, Revision 4 requires that if the cause of the event is not clearly determined, then the results of the investigation shall be presented to SORC for thorough review. Upon completion of the SORC evaluation, the Committee shall make recommendations to the General Manager - Salem Operations on reactor startup.

Contrary To The Above:

On April 23, 1984, the acting Operations Manager approved reactor startup without presenting the investigation to SORC for thorough review and recommendation to the General Manager before reactor startup, after a reactor trip for which the cause had not been clearly determined, even though evidence was available to show that the feedwater flow indication was not as expected and contributed to the cause as determined during a startup on April 29, 1984, following a similar reactor trip on April 27, 1984.

Response to Item A

1. CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED:

1. Procedural steps have been established to close the BF22's when entering Hot Standby. This has been included in the Reactor Trip Procedure (EI I-4.3) and the Minimum Load to Hot Standby Procedure (IOP-5). The procedure of testing the BF19's and BF40's (SP(0) 4.0.5-V-MD) has been changed to add a step to ensure that the BF13's and the BF22's are closed prior to stroking. These changes clarify the existing procedures to prevent recurrence.
2. All reactor trips or safety injections will be reviewed by the Station Operations Review Committee (SORC) prior to startup authorization. Only the General Manager - Salem Operations will have the authority to either grant or deny approval for startup based on the SORC's recommendations.

2. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS:
 1. Operating Procedures are currently being rewritten to change the initial conditions to require that either the lineup for the procedure be performed or a Components in Off-Normal Position report be generated, and all discrepancies be resolved, prior to performing the applicable procedure.
 2. Administrative Directive 16 is in the process of being revised in order to reflect the new requirements.
3. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:
 1. This will be completed for all applicable procedures by July 1986; which will be part of the two year review.
 2. The revision to AD-16 will be issued by August 3, 1984.

Item B

The May 6, 1983 Order Modifying the License Effective Immediately required that the licensee implement and/or maintain the items specified in the licensee's letter dated April 28, 1983.

The licensee's April 28, 1983 letter stated that the Master Equipment List (MEL) was required to be verified complete and accurate for O list systems by May 1983.

Contrary To The Above:

On May 1, 1984, the MEL was not complete and accurate as indicated in the examples below. Even though the MEL identified the components involved as safety related and functionally safety related components respectively in the non-safety related portion of the feedwater system, misclassifications occurred as result of failure of the MEL to also classify them as components in the safety related protection and engineered safety features actuation systems, respectively.

- a) Work Order MD 946229 was not classified as safety related for replacement of the No. 23 Feedwater Flow Nozzle F-659-2; and,
- b) Work Order MD 946237 was not classified as safety related for work on the No. 23 Feedwater Main Regulating Bypass Valve (23BF40).

Reply to Item B:

The report stated that the MEL was not complete and accurate, and cited two examples:

In the first example, a work order involving the feedwater flow nozzle was not classified as safety related, although the nozzle was classified as safety related on the MEL (reference--Salem Unit 2 Controls Instrument Section of MEL, page 65, listing for F-0659). In the second example, a work order involving a feedwater main regulating bypass valve (23BF40) was not classified as safety related, although it was classified as functionally safety related on the MEL (reference--Salem Unit 2 Control Valve Section of MEL, page 17, listing for 23BF040).

The report contends that the MEL was not "complete and accurate" because "misclassifications occurred as a result of failure of the MEL to also classify them as components in the safety related protection and engineered safety features actuation systems." We do not agree that the MEL was not "complete and accurate" for these items, as, in fact, both items were classified as safety related in the MEL. We also do not agree that it is necessary to list these components as part of the protection systems, or that failure to do so is a cause of misclassification. We therefore do not believe a violation has occurred.

It is our belief that the work order misclassifications occurred due to personnel unfamiliarity with the fact that a certain limited number of plant controls components which provide inputs to the reactor protection system for reactor trip or perform functions initiated by the protection system are located in the turbine building by the very nature of their function and plant design, and hence also in locations which are not generally understood to contain safety-related equipment. The detailed logic for these classifications and a listing of the specific equipment is contained in a document, CD-M-60, which is appended to the MEL Instructions for information, but which is not required to be consulted directly when making equipment classifications.

In order to preclude recurrence of such misclassifications the following actions are being taken:

1. To ensure personnel familiarity with the existence of certain safety-related components in the turbine area, and with the definitions of functionally safety related and non-functionally safety related classifications, a specific training program has been developed and is being presented to Station personnel who classify work orders and to appropriate Quality Assurance and Nuclear Engineering personnel.

2. The MEL systems list will be modified to specifically highlight systems which may contain safety-related components in plant areas not normally associated with safety functions. This effort will be complete in August, 1984.
3. Additionally, efforts are underway to provide more frequent issuance of revisions to the MEL. Computer programming has been completed to permit page revisions to the MEL, which will be issued on a more timely basis than the current bi-annual complete issue. This effort will begin in July, 1984, and will ensure that the most up-to-date information is in the possession of users.

Item C

Criterion XVI of 10 CFR 50, Appendix B requires that the licensee's Quality Assurance Program (QAP) establish measures to assure that conditions adverse to quality be promptly identified and corrected. Section 12.2.16 of the SGS-UFSAR, the licensee QAP, requires that the General Manager - Salem Operations assure that conditions adverse to quality are promptly identified and corrected for activities involving operations.

Contrary To The Above:

The licensee did not take adequate corrective action for the events reported in LER 311/84-006, in that adequate procedures have not been developed to ensure that rod position indication could be restored in sufficient time so that the 2A and 2C Emergency Diesel Generators could be tested within the one hour required by Technical Specification 4.8.1.1.2.a.2 for events such as the 2B vital bus being deenergized on March 18, 1984.

Reply to Item C:

1. CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND THE RESULTS ACHIEVED:

The Operations Department had previously identified the need for Operating Procedures addressing the loss of one or more electrical busses. This included Vital and Group busses of all voltages, Vital Instrument busses, all DC busses, and Miscellaneous AC panels. The Department recognized that these new procedures should also be in an Abnormal Operating Procedure format. Therefore, they were included in the AOP project currently underway. These actions were all started prior to the event in question.

2. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS:

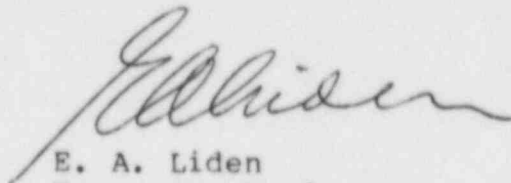
This event exemplified the need for procedures of this type; therefore, it was decided that due to the scope of this project, an appropriate amount of time would be devoted to this undertaking.

3. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED:

The procedures addressing all Vital Busses will be fully implemented by March 1985.

The Notice of Violation requested an analysis of why these problems continue to occur, as well as our views on how the Action Plan is addressing these concerns. This will be addressed in the Management Meeting scheduled for July 19, 1984.

Sincerely,



E. A. Liden
Manager - Nuclear
Licensing and Regulation

C Mr. Donald C. Fischer
Licensing Project Manager

Mr. James Linville
Senior Resident Inspector