U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-440/88017(DRP)

Docket No. 50-440

License No. NPF-30

12/15/88 Date

Licensee: Cleveland Electric Illuminating Company

Post Office Box 5000 Cleveland, OH 44101

Facility Name: Perry Nuclear Power Plant, Unit 1

Inspection At: Perry Site, Perry, Ohio

Inspection Conducted: October 19 through December 2, 1988

Inspectors: K. A. Connaughton

G. F. O'Dwyer

J. W. McCormick-Barger

T. E. Vandel

Approved By: Richard Cooper, Chief

Reactor Projects Section 3B

Inspection Summary

Inspection on October 19 through December 2, 1988 (Report No. 50-440/88017(DRP)) Areas Inspected: Routine, unannounced inspection by resident inspectors of previous inspection items, TI 2515/98, "Information of High Temperature Inside Containment/Drywell in PWR and BWR Plants," operational safety, and surveillance testing, maintenance, engineered safety features, QA program changes, LERs, and an allegation. NRC and licensee management met on November 2, 1988, to discuss licensee performance and recent operational events.

Results: Of the nine areas inspected, two violations were identified in one area; however, in accordance with 10 CFR 2, Appendix C, Section V.A., a Notice of Violation was not issued (failure to verify source range monitor signal-to-noise ratios prior to control rod withdrawals for control rod drive system venting - Paragraph 9); and, (failure to obtain and analyze offgas grab samples within the required time interval with the offgas pretreatment radiation monitor inoperable - Paragraph 9). During this inspection period, the licensee conducted a thirteen day maintenance outage in which repairs were made to the "B" recirculation pump seals and a number of leaking valves located in the drywell. This resulted in a substantial reduction in drywell unidentified leakage.

DETAILS

1. Persons Contacted

a. Cleveland Electric Illuminating Company

+Alvin Kaplan, Vice President, Nuclear Group

C. M. Shuster, Director, Nuclear Engineering Department (NED)
*+M. D. Lyster, General Manager, Perry Plant Operations Department
(PPOD)

R. A. Stratman, Manager, Operations Section, (PPOD)

- * M. L. Wesley, Acting Senior Operations Coordinator (PPOD) V. K. Higaki, Manager, Outage Planning Section (PPOD) *+F. R. Stead, Director, Nuclear Support Department (NSD)
- W. R. Kanda, Manager, Instrumentation and Controls Section (PPTD)
 * S. F. Kensicki, Director, Perry Plant Technical Department (PPTD)

L. L. Vanderhorst, Radiation Protection Section (PPTD)

+R. A. Newkirk, Manager, Licensing and Compliance Section (NSD)

K. Pech, Manager, Technical Section (PPTD)

* E. Riley, Director, Nuclear Quality Assurance Department (NQAD)

*+G. R. Dunn, Compliance Engineer (NSD)

T. A. Boss, Supervisor, Quality Audit Unit (NQAD)

- D. J. Takas, Manager, Mechanical Maintenance Quality Section (NOAD)
- b. U. S. Nuclear Regulatory Commission

R. C. Knop, Chief, Projects Branch 3

+R. W. Cooper, II, Chief, Projects Section 3B *+K. A. Connaughton, Senior Resident Inspector

* G. F. O'Dwyer, Resident Inspector +A. B. Davis, Regional Administrator

*Denotes those attending the exit meeting held on December 2, 1988. +Denotes those attending the November 2, 1988 plant status meeting.

- 2. Licensee Action on Previous Inspection Findings (92701, 92702)
 - a. (Closed) Open Item (440/86021-02(DRP)): Licensee Quality Control (QC) procedures lack adequate details to assure consistent inspections are being performed. This item was identified during an Operational Readiness team inspection conducted July 7 through July 25, 1986. During the inspection, the inspectors noted that licensee contractors' procedures included detailed QC inspector instructions and checklists to be used during QC inspections of work being performed by the contractors. However, the licensee's procedures lacked detailed QC instructions.

In response to the above concern, the licensee reviewed its QC inspection program and developed procedures and checklists to strengthen its control over QC inspection activities. The inspectors reviewed Nuclear Quality Assurance Department

Instruction (NQADI)-0640, "Control of Checklists," Revision 3, dated December 10, 1986, and Nuclear Quality Assurance Department Procedure (NQADP)-1001, "MMQS Inspection Program Control," Revision 8, dated May 13, 1987. The NQADI provided instructions for the preparation, review, approval, and control of inspection checklists, and the NQADP provided the policy for the performance of all Maintenance and Modification Quality Section (MMQS) in-process and final inspection activities. These procedures provided the framework for a prescriptive inspection program that requires the use of QC checklists when existing work orders do not provide adequate inspection details. The licensee developed generic checklists for repetitive tasks in the areas of Electrical, Civil, and Mechanical. The inspectors reviewed the following sample of QC checklists from each of these areas:

Check List No.	Revision	Title
	CIVIL	
C-0002	2	"General Inspection of Structural Steel"
C-0003	2	"Inspection of Structural Steel Bolting"
C-0011	1	"Inspection of Drywall Fire Barriers"
	ELECTRICAL	
E-0001	2	"Insulation Resistance Checks"
E-0002	1	"General Electrical Inspections"
E-0005	2	"General Maintenance of Motor Control Centers"
E-0006	3	"Cable/Wire Terminations"
Check List No.	Revision	<u>Title</u>
	MECHANICAL	
M-0005	3	"General Mechanical Inspections"
M-0007	2	"Welding: In-process and Final Inspection"
M-0008	3	"Piping and Equipment Inspection"

The above checklists were found to contain lists of detailed inspection attributes that should assure comprehensive and uniform inspections. In addition, the licensee's program requires Quality Engineers to generate specific checklists during initial work package reviews when the work packages and/or generic checklists do not provide adequate inspection instruction details. The licensee has adequately addressed the inspectors' concern. This item is considered closed.

b. (Closed) Open Item (440/86027-02(DRP)): Review of licensee responses to observations for improving the Perry LER program. During a NRC Oversight Team Inspection of the licensee's reportable event program conducted on November 5-7, 1986, several observations were identified by the team that might enhance the licensee's ability to identify, correct, and reduce reportable events. In the inspection report cover letter, dated November 18, 1986, the licensee was asked to provide a written response to the observations. The licensee's response was to include a description of actions taken or planned to be taken to address the observations. By letter dated December 22, 1986, the licensee responded to each of the observations.

The Oversight Inspection Team's observations focused on the licensee's corrective action program and other initiatives designed to take the newly-licensed plant from initial startup to safe and efficient full-power operations. The observations were evaluated by the licensee and, in most cases, the licensee determined that existing programs were addressing the observations; however, additional program improvements were initiated to sooner achieve their intended goals.

In March 1988, the NRC conducted an Operational Safety Team Inspection (OSTI) at Perry to evaluate licensee operational performance. As a part of this inspection, NRC inspectors again reviewed the licensee's programs for identifying, analyzing, and correcting operational problems. In general, the inspectors found the licensee's programs to be adequate. The inspectors noted, however, that earlier-identified weaknesses in the licensee's corrective action program were still being addressed by ongoing program improvement efforts.

During this inspection, the inspectors reviewed the licensee's, "Second Quarter 1988 Condition Report and Licensee Event Report Trend Report," dated July 27, 1988, and the latest audit of the licensee's corrective action programs conducted by the licensee's quality assurance organization, documented in Audit Report 88-04, "Effectiveness of Corrective Actions," dated May 12, 1988. The reports demonstrated that the licensee's corrective action programs were identifying and resolving plant problems and that program improvements were being identified and implemented to further improve overall plant performance.

Audit Report 88-04 did, however, identify several corrective action program weaknesses that required additional management attention. The inspectors were informed that the licensee's Nuclear Safety

Review Committee has taken a strong interest in management actions to address the identified weaknesses. Management actions have been taken to further improve the corrective action programs and additional attention is currently being directed toward this area to address the identified weaknesses. This item is considered closed.

(Closed) Violation (440/88012-06(DRP)): Failure to follow surveillance test procedure (SVI)-C41-T2001, "Standby Liquid Control Pump and Valve Operability Test" resulting in standby liquid control (SLC) system inoperability. The inspectors reviewed the licensee's response letter dated October 19, 1988 which described actions taken to correct the identified violation, including actions to prevent future similar occurrences. The inspectors verified by review of operating logs and Condition Report 88-192 that, as described in the licensee's response, SLC system inoperability was recognized during performance of the surveillance test and corrected well within Technical Specification time limits concerning SLC system inoperability. The inspectors determined through interviews with licensee operating personnel that all shift crews were briefed on the circumstances leading to the event and the proper method for conducting surveillance tests, including procedural use and adherence, communications, and independent verification. SVI-C41-T2001 was replaced by three new procedures; SVI-C41-T2001A, SVI-C41-T2001B, and SVI-T2201. These procedures collectively accomplish the same testing as was accomplished utilizing SVI-C41-T2001; however, only one SLC train is rendered inoperable at a time and all system restoration steps, including independent verification, are performed prior to declaring a SLC train operable. A review of other surveillance test procedures was conducted to identify and correct procedural deficiencies similar to those which contributed to this violation. This review was completed by the licensee during this inspection.

No violations or deviations were identified.

3. TI 2515/98, "Informat on on High Temperature Inside Containment/Drywell in PWR and BWR Plants

During this inspection, the inspectors requested and obtained the information requested by the subject TI concerning containment and drywell temperature histories, containment and drywell temperature sensor locations relative to ventilation system airflow paths, and a general assessment concerning the representativeness of the temperature instrument readings. This information was transmitted to the NRC Region III Division of Reactor Projects' Technical Support Staff for forwarding to the NRC Office of Nuclear Reactor Regulation in accordance with the requirements of the TI.

No violations or deviations were identified.

4. Operational Safety Verification (71707)

The inspectors observed control room operations, reviewed applicable logs, and conducted discussions with control room operators during this inspection period. The inspectors verified the operability of selected emergency systems, reviewed tag-out records and verified tracking of Limiting Conditions for Operation associated with affected components. Tours of the intermediate, auxiliary, reactor, and turbine buildings were conducted to observe plant equipment conditions including potential fire hazards, fluid leaks, and excessive vibrations, and to verify that maintenance requests had been initiated for certain pieces of equipment in need of maintenance. The inspectors observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls.

These reviews and observations were conducted to verify that facility operations were in conformance with the requirements established under Technical Specifications, 10 CFR, and administrative procedures.

During daily, routine inspector reviews of licensee Condition Reports the inspectors noted that on two occasions (October 14 and November 19, 1988) during regeneration of condenser offgas dessicant dryers, offgas system dryer chiller loop seals were lost, resulting in increased airborne radioactivity levels in the offgas and turbine buildings. Immediate corrective action following each occurrence was to refill the lost loop seal. Procedure changes were made to require filling of the loop seals just prior to performance of the procedural steps which initiated the first occurrence.

Following the second occurrence, the inspectors reviewed the circumstances surrounding both occurrences and licensee experience in performing the dessicant dryer regeneration evolution. These reviews disclosed that the evolution had been performed many times without incident. By design, maintaining/refilling the loop seals was accomplished manually. Water level indication for the loop seal was not provided. Based upon the above, the inspectors concluded that the loop seals may have been degraded or completely lost over time due to evaporative losses. This would go undetected in the absence of loop seal water level indication. If the loop seals were sufficiently degraded, the loop seals could then be lost under a number of circumstances such as placing associated dryers in service and during dryer regeneration.

As a result of these findings, the inspectors inquired as to whether the licensee had considered further modification of the offgas system operating instructions to require filling of the loop seals prior to each evolution involving the dessicant dryers that could cause the loss of a degraded loop seal or result in a similar event due to the complete absence of a loop seal. The inspectors were informed that offgas system operating instruction (SOI)-N64 was revised on November 22, 1988 to provide additional requirements for filling the subject loop seals prior to all evolutions directly involving the dryers. The inspectors reviewed the subject procedure changes and determined them to be acceptable.

No violations or deviations were identified.

5. Monthly Surveillance Observation (61726)

The inspectors observed surveillance (SVI) tests required by the Technical Specifications:

- a. On October 18, 1988; SVI-R43-T1318, Revision 2, "Diesel Generator and Load Division 2."
- b. On November 28, 1988; SVI-C41-T20004, Revision 2, "Standby Liquid Control Transfer System Pump and Valve Operability Test."

For the above tests the inspectors verified that testing was performed in accordance with procedures, that test instrumentation was calibrated, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that test results conformed with Technical Specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

No violations or deviations were identified.

6. Monthly Maintenance Observation (62703)

Station maintenance activities of safety related systems and components listed below were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides and industry codes or standards and in conformance with Technical Specifications.

The following items were considered during this review: the limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and, fire prevention controls were implemented.

Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety related equipment maintenance which may affect system performance.

The following maintenance activities were observed/reviewed:

On November 1, 1988, a maintenance run of the High Pressure Core Spray (HPCS) Diesel to test, in part, the proper replacement of four commercial fuel oil gauges on the HPCS Diesel as documented by Work Order (WO)-7574, Revision 1 to close Nonconformance Report (NR) Nuclear Engineering Design Section (NEDS)-3325.

Following completion of maintenance on the HPCS Diesel and auxiliary systems, the inspectors verified that these systems had been returned to service properly.

7. Engineered Safety Feature (ESF) Walkdown (71710)

On November 7-9, 1988 during this inspection period, the inspectors performed a detailed walkdown of the accessible portions of the Low Pressure Core Spray (LPCS) System. The system walkdown was conducted using Valve Lineup Instruction (VLI)-E21, Revision 3; the System Operating Instruction (SOI)-E21, Revision 5, and the controlled Piping and Instrumentation Diagrams (P&IDs) for the LPCS System.

During the system walkdown, the inspectors directly observed equipment conditions to verify that hangers and supports were made up properly; appropriate levels of cleanliness were being maintained; piping insulation, heaters, and air circulation systems were installed and operational; valves in the system were installed in accordance with applicable P&IDs and did not exhibit gross packing leakage, bent stems, missing handwheels, or improper labeling; and, that major system components were properly labeled and exhibited no leakage. The inspectors verified that instrumentation associated with the system was properly installed, functioning, and that significant process parameter values were consistent with normal expected values. By direct visual observation or observation of remote position indication, the inspectors verified that valves in the system flow path were in the correct positions as required by the various modes of operation that were required; power was available to the valves; valves required to be locked in position were locked; and, that pipe caps and blank flanges were installed as required.

No violations or deviations were identified.

8. Review of the Licensee's QA Program (35001)

The inspectors conducted a review of the changes included in the sections selected for review of the 1988 FSAR update. Resulting questions were discussed and resolved with the Nuclear Quality Assurance Director and Licensing and Compliance personnel during a telephone call on October 27, 1988. The sections reviewed and a summary of the questions to be revised are as follows:

a. Section 1.8 NRC Regulatory Guides

No questions.

b. Section 3.2 (Table 3.2-1) Equipment Classification

Twelve different examples were discussed of plant equipment items having been reduced (one example) or deleted (eight examples plus three separate fire damper examples) from the previously accepted classification. The licensee committed to revising the table for the following five items:

(1) XXXIV Structures

Item 15. Spent fuel pool and liner.

The construction principal code RDT-G-6T will be replaced.

(2) XXXV Heating, Cooling and Ventilating Systems

Item 36. Drywell Vacuum relief.

The Seismic I code requirement will be replaced.

(3) XXXV Heating, Cooling and Ventilating Systems

Item 8. Emergency Closed Cooling Pump Area Cooling Units

Item 9. Radwaste Building Supply Units

Item 17.b Diesel Generator Building Ventilation Units, Ductwork and Dampers

The commitment, that fire control dampers, located in designated fire barriers, will comply with 10 CFR 50, Appendix B, as stipulated in Note 29, will be replaced for the above listed items.

c. Section 9.5.1.1.4 Fire Protection QA Program

No questions.

d. Section 13.1 Organ zational Structure of Applicant

One item was discussed regarding Figure 13.1-2, see letter "e" following.

e. Section 17.2 Quality Assurance Program Description

The discussion item noted in letter "d" was discussed with the licensee regarding the failure of Figure 13.1-2 as required. They plan to include these revisions in their regular update scheduled for March 1989.

These items will be reviewed at that time.

9. Licensee Event Reports Followup (92700)

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements, were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with Technical Specifications.

LER	87058-LL	Control Rods were Withdrawn Prior to Performing Source Range Monitors Signal to Noise Ratio Verification in Violation of Technical Specification
LER	87071-LL	Faulty Temperature Switch Module Results in a Reactor Water Cleanup Isolation During the Performance of a Routine Channel Check
LER	87072-LL	Reactor Scran and HPCS Injection Caused by Loss of Feedwater Flow Due to Improper Transfer of Station Loads
LER	87073-LL	Spienoid Air Pilot Valves Stick Due to Excessive Heat Exposure Resulting in Main Steam Isolation Valves Slow Closure and Subsequent Manual Reactor Scram During Shutdown
LER	87073-1L	Solenoid Air Pilot Valves Stick Due to Excessive Heat Exposure Resulting in Main Steam Isolation Valves Slow Closure and Subsequent Manual Reactor Scram During Shutdown
LER	88010-LL	Inadequate Instructions Result in Loss of Auxiliary Building Ventilation and Subsequent Reactor Water Cleanup System Containment Isolations
LER	88013-LL	Flow Indication Inaccuracy Coupled with Oversensitive Flow Control Valves Result in Indicated High Differential Flow and Reactor Water Cleanup System Isolation
LER	88014-LL	High Reactor Vessel Level Following Opening of Main Steam Isolation Valves Results in Reactor Protection System Actuation Due to Faulty Relay
LER	88016-LL	Personnel Error Results in Deenergizing Auxiliary Building Ventilation Fan Trip Relay Causing Loss of Ventilation and Reactor Water Cleanup Containment Isolation
LER	88027-LL	High Pressure Core Spray Placed in Secured Status Due to Failed Leak Detection Transmitter
LER	88028-LL	Auxiliary Boiler Exhaust and Other Indeterminate Problems Cause Trips of Ethylene Oxide Detectors Resulting in Control Room HVAC Realignment to Emergency Recirculation
LER	88029-LL	Inappropriate Lineup of the Standby Liquid Control System During the Performance of a Surveillance Instruction Results in Both Trains Inoperable at the Same Time
LER	88030-LL	Offgas Grab Sample Not Taken in Accordance with Technical Specifications While Pretreatment Radiation Monitor Inoperable

LER 88037-LL Control Room HVAC Shifted to Emergency Recirculation Due to High Indications on Ethylene Oxide Detectors Caused from Auxiliary Boiler Exhaust

Regarding LER 87058-LL, while in Operational Condition 4 (Cold Shutdown), the licensee performed seven individual control rod withdrawals to accomplish control rod drive system venting following partial draining of the system for maintenance. Technical Specifications required verification of source range monitor signal-to-noise ratios prior to control rod withdrawal. While the source range monitors were operable at the time, Technical Specification surveillance procedures for Operational Condition 4, which are performed as part of the Technical Specification Rounds (TSR) for specific operational modes, did not require verification of source range monitor signal-to-noise ratios prior to control rod withdrawal. Additionally, the system operating instruction utilized for venting the control rod drive system via rod withdrawal did not reflect this requirement. In order to prevent recurrence, the licensee revised these instructions to incorporate the required signal-to-noise ratio verifications. Additionally, the licensee reviewed the TSRs to ensure that all applicable periodic and conditional surveillances are captured and performed as required. The inspectors verified these actions were taken by review of the affected procedures. Failure to perform source range monitor signal-to-noise ratio verifications prior to control rod withdrawal as specified in Technical Specification 3.3.7.6 is a violation (440/88017-01(DRP)). This violation meets the tests of 10 CFR 2, Appendix C, Section V.G; consequently no notice of violation will be issued and this matter is considered closed.

Regarding LER 87072-LL, inspectors' review of this event and evaluation of licensee actions were documented in NRC Inspection Report 440/87023(DRP).

Regarding LER 87073-LL and LER 87073-1L, these events resulted in the conduct of two NRC Augmented Inspection Team (AIT) inspections to perform an in-depth evaluation of licensee actions to determine the root cause of the MSIV failures and corrective actions. The results of the AIT inspections are documented in NRC Inspection Reports 440/87024 and 440/87027.

Regarding LER 88029-LL, this event was the subject of a Severity Level IV violation (440/88012-06(DRP)). Inspectors review and closeout of this violation is documented in Paragraph 3.c. of this inspection report.

Regarding LER 88030-LL, an offgas grab sample was not obtained and analyzed in accordance with the once-per-8-hour frequency requirement which had been established as a result of offgas pre-treatment radiation monitor inoperability. The licensee identified this matter and determined that the radiation chemistry technician involved was unaware of the requirement due to an inadequate shift turnover briefing and an incomplete review of the previous shift logs. As a result of this event, the individuals were counseled by licensee management and Plant Administrative Procedure (PAP)-1102, "Plant Chemistry Control Program" was revised to incorporate shift turnover guidelines which required that

the oncoming lead technician review the Active LCO Log and the Daily LCO Surveillance Log Sheet at the beginning of each shift. Logged items requiring action by chemistry personnel were required to be initialed by the technician as evidence that the review was performed and acknowledgement of responsibility for the item. Failure to obtain and analyze offgas grab samples once per 8 hours with the offgas pretreatment radiation monitor inoperable in accordance with Technical Specification 3.3.7.1 is a violation (440/88030-02(DRP)). This violation meets the tests of 10 CFR 2, Appendix C, Section V.G; consequently no notice of violation will be issued and this matter is considered closed.

10. Allegation Followup (99014)

Allegation

In 1984, an individual employed by Johnson Controls Inc. at the Perry site identified a concern involving the use of design data contained on Pressure Test Diagrams (hereafter referred to as 614 series drawings) for completing ASME N-5 data reports for instrument piping installations. The individual communicated this concern to the licensee via the licensee's Call for Quality program. Specifically, the individual was concerned that from time-to-time, data on the 614 series drawings was inconsistent with data contained in the design specifications. When such inconsistencies were identified, they were communicated to the licensee's engineering organization via Field Questions. The engineering organization would typically specify that the data from the 614 series drawings be utilized for N-5 data report completion in lieu of the data from the design specifications. The alleger contended that the N-5 data reports must be based upon the design specification and that in such cases, where discrepancies between the design specification and the 614 series drawings existed, completion of the N-5 reports prior to incorporation of the data contained on the 614 series drawings into the design specification was in violation of the ASME Code, Section III. By letter dated January 16, 1985, the licensee informed the alleger that in order to address his concern, a change had been made to the applicable design specification to specify the technical requirements for contractor design, fabrication, testing, and documentation. Further, the specification was changed to provide a means for resolving conflicts between design documents via Field Questions. The alleger brought this matter to the NRC's attention in May 1988 because the alleger could not determine from a reading of the January 16, 1985 letter whether his concern had been fully addressed.

Findings

The inspectors reviewed the licensee's Call for Quality file associated with this allegation in order to determine whether or not the changes to the applicable design specification addressed the alleger's concern and, moreover, to determine that activities associated with N-5 data report preparation and component N-stamping were in conformance with ASME Code requirements. The Call for Quality file included relevant correspondence between Johnson Controls, the licensee, and The Hartford Steam Boiler, (the ANI inspection agency) concerning this matter.

As stated in the above allegation description, prior to November 1984, discrepancies between design data contained in piping design specifications and 614 series drawings were resolved by the licensee's engineering organization on a case-by-case basis via Field Question responses. Generic guidance clarifying the use of various design documents, including the 614 series drawings, was first provided by the licensee to Johnson Controls Inc. in response to Field Question No. 41437, dated November 12, 1984.

By letter dated December 4, 1984, Johnson Controls Inc. acknowledged its understanding of the guidance contained in the Field Question response and informed the licensee of a potential conflict with the ASME Code which mirrored the alleger's concern. Specifically, Johnson Controls Inc. pointed out that the licensee had taken the position that the piping design specifications need not be revised and complete until such time as they are submitted for the licensing process. According to Johnson Controls, this was contrary to the requirements as outlined in ASME Code, Section III, Subsection NA-3250, as clarified through Interpretation III-81-129 which asked and answered the questions: (1) May components be fabricated and N-stamped to revisions to the design specifications which have not been certified by a registered Professional Engineer? - originally answered "yes" and readdressed through further consideration and answered "no;" and, (2) Must changes to the design specifications be incorporated prior to N-stamping of components? answered "no." Based upon the fact that Johnson Controls was going to begin the N-stamp process before submittal of the design specification for licensing purposes, Johnson Controls requested the licensee to revise the design specification to reflect the information as contained in the 614 series drawings prior to N-stamping of components and/or systems under Johnson Controls' Certificate of Authorization.

By letter dated December 10, 1984, the licensee acknowledged the validity of the concern expressed by Johnson Controls and informed Johnson Controls of the steps to be taken to comply with the referenced ASME Code requirements. On January 4, 1985, the licensee issued Engineering Change Notice No. 25355-90-3147 to design specification SP-90-4549-00. This revision to the piping design specification incorporated the clarification earlier provided in response to Field Question No. 41437 concerning the use of the various design documents for fabrication, installation, testing, and ASME Code documentation completion.

Based upon the inspector's review, the inspector concluded that the alleger's concern was appropriately resolved by the licensee. It should be noted that the 614 series drawings were controlled, engineer-approved documents. The discrepancies between design data contained in the design specifications and the 614 series drawings did not generally represent design errors. The data on the 614 series drawings for pneumatic test pressure and design pressure and temperature values for ASME N-5/NR-1 completion reflected design information originally contained in the design specifications which was modified, as necessary, to accommodate additional considerations, such as; lack of isolation, components with more limiting design pressures/temperatures, and ASME/ANSI B31.1

boundaries. Modification of the piping design specification to explicitly indicate the appropriate use of the various sources for design data ensured ASME Code compliance prior to the performance of N-stamping by Johnson Controls Inc. This allegation is considered closed.

11. Plant Status Meetings (30702)

On November 2, 1988, NRC management met with CEI management at NRC Headquarters in Washington, D.C. to discuss the current status of the plant, recent events and licensee initiatives to improve the quality of plant operating and maintenance activities. These meetings are being held on a periodic (initially monthly) basis.

12. Violations For Which A "Notice of Violation" Will Not Be Issued

The NRC uses the Notice of Violation as a standard method for formalizing the existence of a violation of a legally binding requirement. However, because the NRC wants to encourage and support licensees' initiatives for self-identification and correction of problems, the NRC will not generally issue a Notice of Violation for a violation that meets the tests of 10 CFR 2, Appendix C, Section V.G. These tests are: (1) the violation was identified by the licensee; (2) the violation would be categorized as Severity Level IV or V; (3) the violation was reported to the NRC, if required; 4) the violation will be corrected, including measures to prevent recurrence, within a reasonable time period; and (5) it was not a violation that could reasonably be expected to have been prevented by the licensee's corrective action for a previous violation. Violations of regulatory requirements identified during the inspection for which a Notice of Violation will not be issued are discussed in Paragraph 9.

13. Exit Interviews (30703)

The inspectors met with the licensee representatives denoted in Paragraph 1 throughout the inspection period and on December 2, 1988. The inspectors summarized the scope and results of the inspection and discussed the likely content of the inspection report. The licensee did not indicate that any of the information disclosed during the inspection could be considered proprietary in nature.