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ARTHUR E. LUNDVALL, JR.
VICE PRESIDENT
SUPPLY

December 21, 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. Edward C. Wenzinger, Chief
Projects Branch #2
Division of Project & Resident Programs

Gentlemen:

This refers to Inspection Report 50-317/84-23, 50-318/84-23; which transmitted two items of apparent noncompliance with NRC requirements. Enclosure (1) to this letter is a written statement in reply to that item noted in your letter of November 21, 1984.

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

Very truly yours,

A. E. Lundvall, Jr.

AEL/LOW/tlm

Enclosure

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

ENCLOSURE (1)

REPLY TO APPENDIX A OF NRC INSPECTION REPORT 50-317/84-23; 50-318/84-23

ITEM A.1.

We have reviewed the circumstances that led to the apparent violation of Technical Specification 6.8.1.a referred to by the subject inspection report. This event was caused by the failure to fully implement the administrative controls for blank flanges specified by Calvert Cliffs Instruction-117D, "Lifted Lead and Temporary Jumper Logs." Accordingly, the corrective actions cited below have been implemented to ensure that similar violations will not recur in the future.

Calvert Cliffs Instruction-117D has been changed to require inclusion of a sketch or marked-up drawing that shows the proposed location of any blank flanges. This will more clearly specify the potential for altering system operating characteristics to both Operations and Maintenance personnel.

This incident and the prevention of similar occurrences was discussed at four separate safety meetings with maintenance personnel. During these meetings, the requirements of CCI-117D and the need for improved communications between Maintenance and Operations personnel was stressed. In addition, the General Supervisor - Operations discussed the incident with the Shift Supervisors emphasizing the importance of good communications.

ITEM A.2

We have reviewed the circumstances that led to the apparent violation of Technical Specification 6.12 referred to by the subject inspection report. This event was caused by the failure to replace the barricades and postings previously installed at the access to #21 Reactor Coolant Pump bay. Accordingly, the corrective actions cited below have been implemented to ensure that similar violations will not recur in the future.

The immediate corrective action taken was the re-establishment of the rope barricade and High Radiation Area sign. To prevent recurrence, a self-closing swing gate with an attached High Radiation Area sign was substituted for the standard barricade at the access to the ladder. Such gates have been successfully used in other plant locations to aid radiation workers in re-establishing proper barricades. To foster improvement in worker compliance with the Radiation Protection Program, the General Supervisor - Operations issued reminders to the Operations staff regarding radiation area posting requirements. Furthermore, all employees initially receive General Orientation Training which discusses the radiation area posting requirements.