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SUBJECT: Responds to NRC 890222 ltr re violations noted in Insp Rept 50-244/89-17.

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March 26, 1990

Mr. William T. Russell
Regional Administrator
U.S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, Pennsylvania 19406

Subject: Response to Notices of Violation
Inspection Report No. 50-244/89-17
R.E. Ginna Nuclear Power Plant
Docket No. 50-244

Dear Mr. Russell:

This letter is in response to the February 22, 1989 letter from Jon R. Johnson, Chief, Projects Branch No. 3 to Robert E. Smith, Senior Vice President, RG&E, which transmitted Inspection Report No. 50-244/89-17. In that report, two violations were identified. The following provides a reply to the violations pursuant to 10 CFR 2.201.

RESTATEMENT OF VIOLATIONS

During inspection at the R.E. Ginna Nuclear Power Plant from December 12, 1989 through January 8, 1990, the following violations were identified and evaluated in accordance with the NRC Enforcement Policy (10 CFR 2, Appendix C):

A. 10 CFR 50, Appendix B, Criterion XVI, and the Ginna Quality Assurance Manual, Section 16, require prompt identification and correction of conditions adverse to quality including failures, malfunctions, deficiencies, defective material and equipment, and nonconformances.

Contrary to the above, a safety injection system design deficiency was not promptly identified and corrected when corporate engineering was notified on or before October 20, 1989 that failure of the safety injection block/unblock switch could block automatic safety injection actuation on low pressurizer pressure or low steam line pressure. Corporate engineering did not conclude that this problem existed at Ginna until about November 17, 1989, and site technical personnel were not informed about the deficiency until December 19, 1989.

This is a Severity Level IV violation (Supplement I).

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B. 10 CFR 50, Appendix B, Criterion V, and the Ginna Quality Assurance Manual, Section 5, require activities affecting quality to be accomplished in accordance with instructions, procedures, or drawings which include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished.

Contrary to the above, on December 15, 1989, maintenance was performed on a safety-related motor-operated valve in the safety injection system in accordance with a procedure which included an inappropriate torque specification.

This is a Severity Level V violation (Supplement I).

RESPONSE TO VIOLATION A

1. RG&E Position on Existence of Violation
Rochester Gas and Electric Corporation (RG&E) concurs that a violation of Appendix B, Criterion XVI occurred. RG&E recognizes that communication between corporate engineering and site personnel on issues of potential safety significance should be formalized. Our efforts to address this concern are provided in Section 4, "Long Term Enhancements". As explained below, RG&E also believes that with respect to the issue identified on October 20, 1989, we acted in a manner consistent with the safety significance of the matter.

2. Reason for Violation
As Inspection Report No. 50-244/89-17 (p. 7) indicates, RG&E received notice on October 20, 1989, from Westinghouse Electric Corporation (Westinghouse) of an apparent generic design deficiency related to the type of safety injection (SI) block/unblock switch used at various Westinghouse reactors. The Westinghouse letter, dated October 12, 1989, concluded that a "single failure of the switch (Westinghouse OT2) could block either the automatic low pressurizer pressure or the low steamline pressure SI signal in both trains" [emphasis supplied]. The letter also stated that the probability of switch failure was "10^{-3} - 10^{-5}/yr" and that, while a design change was recommended, the situation was "not an immediate safety concern."

In addition, the Westinghouse letter referred to a Licensee Event Report (LER), No. 88-007-00, submitted by Wisconsin Electric Power Company (Wisconsin Electric) on September 16, 1988, concerning the same issue at the Point Beach Nuclear Plant (Point Beach). The Wisconsin Electric LER concluded that "this condition will not have a significant impact on the health and safety of the general public or the employees of the Point Beach Nuclear Plant."

The LER noted that the Point Beach facility was operating at 100% capacity when the concern was identified and that design change would not be made until the next scheduled outage.

Upon receipt of the Westinghouse notification on October 20, 1989, RG&E (corporate) initiated a timely review for applicability to Ginna Station. Based on the Wisconsin Electric LER and on Westinghouse's calculation of the low probability of switch failure, it was apparent that the matter did not constitute an immediate safety concern. When it was identified that the switch configuration was applicable to Ginna Station, an internal engineering recommendation was made consistent with the guidance of the Westinghouse letter and attached LER, that an EWR be initiated. This was completed on November 17, 1989. This recommendation was then evaluated within Nuclear Safety and Licensing, resulting in a discussion with site technical support personnel relative to this situation on December 19, 1989. On December 20, site personnel initiated a Ginna Station Event Report per Procedure A-25.1 (Event No. 89-168). The event report indicated that the site Plant Operations Review Committee (PORC) had, on December 20, 1989, concluded that plant operation could continue for the following reasons:

1. Westinghouse stated that the probability of failure was very low (i.e., 10^{-3} to 10^{-5}/yr);

2. Emergency Operating Procedures directed Operators to use manual SI initiation where indicators show automatic initiation has failed;

3. A separate automatic SI initiating mechanism would activate when containment pressure reached 4 psig;

4. During depressurization, a bistable light will alert operators of a blocked SI signal; and

5. Visual verification of the SI switch plunger position indicates that the contacts are in the proper position.

The violation states that the time between October 20, 1989, when RG&E (corporate) was notified by Westinghouse, and the communication of this information to the site technical staff on December 19, 1989, shows that the SI design deficiency was not promptly identified and corrected, and indicates problems in communication between corporate engineering and site personnel. While RG&E does not deny this violation, we believe that the actions taken by RG&E were appropriate in view of RG&E's preliminary conclusion that the issue did not constitute an immediate safety concern.

RG&E believes that Appendix B, Criterion XVI does not establish a precise time limit for resolution of safety issues. Rather, issues such as "promptness" or "timeliness" are subjective matters that inherently depend upon the safety significance of the situation. Given that RG&E had a documented recommendation from Westinghouse that no immediate safety concern existed (as corroborated by the Point Beach LER), its actions toward resolution of the issue were prompt and timely. Any other interpretations of Criterion XVI would be counter to public health and safety because it would require licensees to treat all deficiencies or non-conforming items the same (i.e., regardless of safety significance).

This same basic philosophy was affirmed in an analogous context in recent guidance issued by NRC's Office of Nuclear Reactor Regulation (NRR). Specifically, on July 19, 1989, Dr. T.E. Murley, Director, NRC/NRR, sent a memorandum to all of the regional administrators entitled "Guidance on Action To Be Taken Following Discovery of Potentially Nonconforming Equipment." In his memorandum, Dr. Murley stated that "[t]here is no generally appropriate timeframe in which operability determinations should be made." For equipment which is "clearly inoperable," an immediate declaration of inoperability should be made and the appropriate technical specifications followed. However, Dr. Murley's memorandum contrasts this situation with those where equipment nonconformances simply raise the issue of operability. In such situations Dr. Murley states that:

> operability determinations should be made by licensees as soon as practicable, and in a timeframe commensurate with the applicable equipment's importance to safety, using the best information available (e.g., analyses, a test or partial test, experience with operating events, engineering judgement or a combination of the factors) (emphasis supplied).

Although this guidance relates to timing of operability determinations, it is equally appropriate with respect to resolution of open items under Criterion XVI. Consistent with this philosophy and based on the best information available, future cases of this type will be resolved "as soon as practicable" and in a time commensurate with the safety significance of the matter. Communication between corporate and site personnel will be initiated promptly once applicability to Ginna Station is determined.

3. Corrective Steps Which Have Been Taken and the Results Achieved

Corporate and site technical staff and the PORC have reviewed the circumstances surrounding the potentially generic design deficiency related to the control room SI block/unblock switch. As stated in LER 89-016, the following actions were taken:

- Knowledgeable personnel inspected the plunger position of the SI Block/Unblock Switch and verified that the switch contacts were in the proper position.

- Operating Procedure O-1.1 (Plant Heatup From Cold Shutdown to Hot Shutdown) was changed to add the following note and check-off to Step 5.11.6:

  NOTE: Prior to placing the SI Block/Unblock Switch to the normal position, station an operator inside the MCB in direct observation of the SI Block/Unblock Switch to observe that both plunger tips are recessed inward after the switch is placed to normal position.

  Block switch plunger tips position inward _____

- An RG&E operator aid tag was placed on the MCB adjacent to the SI Block/Unblock Switch denoting the note from O-1.1.

- An RG&E operator aid tag was also placed inside the MCB adjacent to the rear of the SI Block/Unblock Switch stating the following: This is the switch we verify that the plunger's tips are recessed inward when the switch is placed to normal (labeled LAK).

- A spare switch of similar design has been placed in the Control Room for the purpose of training the operators to recognize the differences in plunger position.

These actions are considered adequate to provide reasonable assurance of SI system operability until the situation can be permanently dispositioned. Finally, EWR 5025 was initiated to provide for the installation of independent SI block/unblock switches for each SI train which is planned for the 1991 refueling outage.

4. Corrective Steps Which Will Be Taken to Avoid Further Violation

RG&E has recently taken steps to upgrade the overall corrective action program for Ginna Station. The need for improvements was noted during the course of the RHR System Safety System Functional Inspection (SSFI), and is also considered appropriate due to RG&E's initiation of a comprehensive Configuration Management/Design Basis Program. We are working with the NUMARC Design Basis Issues Working Group to develop an improved problem identification and resolution program.

The improved program will:

- Improve the process of identifying, analyzing, and resolving problems;

- Improve the RG&E internal review process, including formalized means of communication between corporate engineering and site personnel on issues of potential safety significance; and

Part of the implementation of this effort will include specific procedural upgrades, enhancement of our corrective action tracking system, and the issuance of a corporate policy which addresses problem identification and reporting. We believe that this broad effort, when fully implemented, will improve our capability to consistently identify and disposition potential safety issues commensurate with their significance.

5. Date When Full Compliance Will Be Achieved
Long term and short term actions and schedules have been described above. Formal guidance concerning communication between corporate and site personnel on identified problem issues is under development, and is targeted for completion by July 1990.

RESPONSE TO VIOLATION B

Rochester Gas and Electric concurs with this violation as stated below.

Reason for Violation
Rochester Gas and Electric agrees that Ginna Station does not have an established written policy regarding consideration of inherent inaccuracy of calibrated measuring and test equipment (M&TE) when developing acceptance criteria.

As a common practice, torquing methods address only instrument "indication" and are not meant to include the instrument accuracy. This practice is based on the fact that torque is only a general indicator of bolting pre-load because of the inaccuracies, e.g., lubrication, thread fit, thread condition, etc., inherent in the torque equation. When highly accurate bolt pre-loading is required, means other than torque is used, i.e., stud elongation to determine bolt pre-load.

The Corrective Steps Which Have Been Taken and the Results Achieved
Due to the successful completion of post maintenance testing, no action regarding the valve packing adjustment has been taken.

A-1603.4, "Work Order Scheduling" was revised to require work and testing to be completed on individual trains prior to starting maintenance on a redundant train.

The Corrective Steps Which Will Be Taken to Avoid Further Violation

1. Administrative procedure A-1603.3, "Work Order Planning" will be revised to state a Ginna Station policy regarding consideration of M&TE inherent inaccuracy and provide direction for development of acceptance criteria utilizing this equipment.

2. A new procedure for packing adjustment is being developed to provide specific direction for adjustment of valves repacked under the Valve Packing Improvement Program and to provide a method of maintaining and updating valve packing data.

The Date When Full Compliance Will Be Achieved

The anticipated effective date of the above procedures is May 1, 1990, for the maintenance procedures and June 30, 1990, for the administrative procedure.

Very truly yours,

Robert C. Mecredy
Division Manager
Nuclear Production

GJW\093
Enclosures

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