PSEG Nuclear LLC
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LR-N04-0241

PSEG Nuclear LLC

JUN 0 8 2004

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

REPLY TO NOTICE OF VIOLATION EA-04-086
HOPE CREEK GENERATING STATION
DOCKET NO. 50-354

On May 10, 2004, the NRC issued a, "Final Significance Determination for a White Finding and Notice of Violation," concerning the 'A' station service water system (SSWS) traveling screen failure that occurred on July 1, 2003. Attachment 1 provides PSEG Nuclear's response to the Notice of Violation.

Should you have any questions concerning this submittal, please contact Brian Thomas at 856-339-2022.

Sincerely,

Michael Brothers
Vice President – Site Operations

IE01

C Mr. Hubert J. Miller
Administrator - Region I
U. S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

U. S. Nuclear Regulatory Commission
Attn: Mr. D. Collins, Licensing Project Manager – Hope Creek
Mail Stop O8C2
Washington, DC 20555

USNRC Resident Inspector (X24)
Hope Creek Generating Station

Mr. K. Tosch, Manager IV
Bureau of Nuclear Engineering
P.O. Box 415
Trenton, NJ 08625

Attachment 1
LR-N04-0241

Reply to Notice of Violation EA-04-086

NOTICE OF VIOLATION

PSEG Nuclear LLC
Hope Creek Nuclear Generating Station

Docket No. 50-354
License No. NPF-57
EA-04-086

During an NRC inspection conducted between September 28, 2003 and December 31, 2003, for which our exit meeting was held on January 21, 2004, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

> 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures and Drawings" requires that activities affecting the quality of safety-related equipment functions be accomplished in accordance with documented instructions, procedures or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. Instructions, procedures or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished.
>
> Contrary to the above, between June 20 and June 26, 2003, the licensee replaced the head-shaft on the "A" service water system traveling screen under Work Order 60037345. Procedures directed to be used by the work order failed to contain adequate instructions to perform the maintenance and were not followed, resulting in the subsequent failure of the traveling screen on July 1, 2003. Specifically,
>
> 1. Procedure HC.MD-CM.EP-0003(Q), "Service Water Traveling Screens Overhaul and Repair," Revision 11, did not include appropriate quantitative acceptance criteria to ensure that the vendor-supplied service water system traveling screen head-shaft key was installed correctly. As a result, the key was cut too short during installation.
>
> 2. Procedure HC.MD-PM.EP-0001(Q), "Service Water Traveling Screen 12 Month Preventative Maintenance," Section 5.4.1, provided acceptance criteria to level the traveling water screen head-shaft while applying tension on the basket chains. The licensee determined that the traveling screen basket chains had not been tensioned adequately during the work, and the licensee failed to document in Work Order 60037345 that the procedure had been completed.

This violation is associated with a WHITE significance determination process finding.

Reply to Notice of Violation EA-04-086

Reason for Violation

The apparent cause of the failure of the "A" SSWS traveling screen was attributed to the head shaft key being cut too short due to the lack of procedural guidance for the minimum key length.

The failure to properly tension the basket chains under Work Order 60037345 was due to the procedure steps being marked as "not applicable" by Maintenance personnel.

The failure to document the work performed for the tensioning of the traveling screen basket chains in the work order is attributed to less than adequate adherence to maintenance standards for documenting work performed.

Corrective Actions Taken

1. Procedure HC.MD-CM.EP-0003(Q), "Service Water Traveling Screen Overhaul and Repair," was revised on October 10, 2003, to add a note for the minimum gib key length. A step was also added to this procedure, to direct that the screen needs to be tensioned in accordance with procedure HC.MD-PM.EP-0001, "Service Water Traveling Screen 12 Month Preventive Maintenance." (Order 70032466 Act 0060)

2. Procedure HC.MD-PM.EP-0001(Q), "Service Water Traveling Screen 12 Month Preventive Maintenance," was revised on October 22, 2003, to add a step to run the screen with a test pin after the screen is properly tensioned, if the procedure was being performed to correct mechanical binding or a shear pin failure, prior to returning the screen to service. (Order 70032466 Act 0070)

3. Procedure HC.OP-SO.EP-0001(Q), "Service Water Traveling Screens System Operation," was revised on October 29, 2003, to include steps to run the screen with a test pin if the screen failed due to a shear pin failure. If the test pin fails during one revolution, then further corrective maintenance is required (possible tension adjustment needed) before the screen can be returned to service. (Order 70032466 Act 0080)

4. Procedure HC.MD-PM-EP-0001, was revised on February 7, 2004, to include a new methodology of tensioning the traveling screens by use of spring compression, headshaft level, and float. (Order 70034020 Act 0090 and Order 70032795 Act 0080)

5. On December 15, 2003, the Hope Creek Maintenance Manager issued a memo to the maintenance superintendents and supervisors concerning procedure

use/adherence and work practices/standards and the necessity to adhere to the maintenance standards. (Order 70033836 Activity 0210)

6. Procedure SH.MD-DG.ZZ-0007(Z), "Maintenance Standards," was revised on April 15, 2004, to add a checklist for Maintenance Technicians and Supervisors regarding the proper documentation of work performed. (Order 70032507 Activity 0060).

7. Toolbox training was developed for Maintenance personnel to provide appropriate knowledge in the regulatory requirements associated with maintenance work documentation, completion and record keeping. The training information was developed on February 1, 2004. The training is being conducted as part of the 2004 Maintenance continuing training. As of the middle of May 2004, approximately 50% of maintenance personnel have completed this training. (Order 70032507 Acts 0070 and 0080)

Corrective Actions to Prevent Recurrence

The corrective actions to prevent recurrence are contained in the previous section.

Full Compliance Achieved

PSEG Nuclear is in full compliance.