

**GPU Nuclear**  
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Forked River, New Jersey 08731  
609-693-6000  
Writer's Direct Dial Number:  
October 25, 1982

Mr. Richard W. Starostecki, Director  
Division of Project and Resident Programs  
U.S. Nuclear Regulatory Commission  
Region I  
631 Park Avenue  
King of Prussia, PA 19406

Dear Mr. Starostecki:

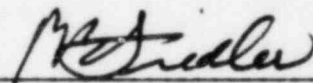
Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Inspection Report No. 50-219/82-20

This letter is submitted in response to your letter of September 22, 1982, regarding the findings of the routine inspection conducted by Messrs. Cowgill and Thomas on August 3 - September 7, 1982.

Pursuant to the provisions of 10 CFR 2.201, attached are our responses to the violations identified in Appendix A of your correspondence. We realize that the time limitation specified for response is exceeded; however, a three day extension was requested, and granted on October 22, 1982 by Mr. L. Norrholm of NRC Region I.

If there are any questions regarding the enclosed information, please contact me or Mr. Michael Laggart of my staff at (609) 974-4643.

Very truly yours,

  
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Peter B. Fiedler  
Vice President and Director  
Oyster Creek

PBF:PFC:lse  
Attachments

cc: Mr. Ronald C. Haynes, Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

NRC Resident Inspector  
Oyster Creek Nuclear Generating Station  
Forked River, NJ 08731

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ATTACHMENT

The following information provides a response to the "Notice of Violation" identified in the US NRC letter dated September 22, 1982.

Violation A:

Technical Specification 6.8.1 requires that procedures be established, implemented, and maintained. Procedure 108, revision 29, April 26, 1982, "Equipment Control", requires that all valves, breakers, or switches affecting safety shall be in a position controlled by a procedure or shall be tagged.

Contrary to the above, on August 14, 1982, the Number 1 Diesel Generator lube oil heater and recirculation pump control switch was found in the "off" position contrary to the operating procedure and was not tagged.

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

Response:

We concur with the violation as stated.

Immediate corrective action taken was to return the No. 1 Diesel Generator (DG) lube oil heater and recirculation pump control switch to the "on" position.

A critique was conducted by the Preventive Maintenance Manager with the supervisor in charge of DG battery surveillance and the electrical maintenance personnel who performed a weekly battery surveillance on August 13, 1982. Although the electrical maintenance personnel contended that the lube oil heater and recirculation pump control switch had not been touched during that weekly surveillance, it was confirmed that the switch had been routinely turned off to reduce noise and allow for better communication during monthly battery surveillances. This was done under the supervisor's cognizance. As stated in Section 5.1 of the inspection report, there is no procedural step in the surveillance procedure that allows the pump and heater to be turned off.

We believe this situation to be isolated with regard to the supervisor involved. This individual has been directed to read and review with the Preventive Maintenance Manager the procedures which establish requirements for procedure control, document control, the conduct of maintenance and equipment control, and to reemphasize to his maintenance personnel their procedure compliance responsibilities. This is expected to be completed by October 25, 1982.

Full compliance was achieved with the implementation of our immediate corrective action.

## Violation B

Technical Specification 6.11 requires that procedures for personnel radiation protection be prepared consistent with 10 CFR 20 for all operations involving personnel radiation exposure. 10 CFR 20.203 requires that each access point to a high radiation area shall be locked, except when access is required, with positive control over each individual entry. It also requires that the controls be established such that no individual will be prevented from leaving a high radiation area.

Contrary to the above, Procedure 902.6, Revision 12, June 8, 1982, "General Drywell Clearance" was not consistent with 10 CFR 20.203 in that it did not have adequate provisions to assure that all personnel had exited the drywell, a high radiation area, before locking the access door. This contributed to two individuals being locked in the drywell with no means of exit for about twenty minutes on August 16, 1982.

This is a Severity Level IV Violation (Supplement IV).

## Response

We concur with the violation as stated.

As identified in Section 5.2 of the inspection report, the corrective actions taken include the following:

A critique of the event was conducted with all personnel involved. Although the procedure did not assign exit verification responsibility, the individual who locked the drywell did not check with the control point watch prior to doing so. As a result of this incident, the radiological controls technician who closed and locked the drywell airlock door resigned.

A revision to the "General Drywell Clearance" Procedure (902.6) was issued to require a public address announcement be made of the intent to lock the drywell. This announcement notifies those within the drywell and alerts the control point to verify that all personnel have been logged out of the drywell and have picked up their ID cards and exposure record cards prior to drywell closure. The radiological controls technician and site protection officer at the control point are now required to complete a drywell closure sign-off sheet after proper exit verification is made. The procedure revision was made effective on September 6, 1982, and will be made required reading for all radiological controls technicians and site protection officers.

With regard to the inspector's concern for lack of communication of this event to facility management stated in Section 5.2 of the inspection report, a memorandum from the Manager - Radiological Controls was being disseminated among Rad Con supervision at the time of the event to provide guidelines for timely notification to management of various types of events. Continual emphasis is placed upon the logging and communication of significant events in the area of operations.

Full compliance was achieved with the procedure revision on September 6, 1982.