GPU Nuclear

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C321-95-2088
March 6, 1995

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

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Reply to a Notice of Violation
(Inspection Report 50-219/94-29)

In accordance with 10 CFR 2.201, Attachment I provides GPU Nuclear's reply to the Notice of Violation as documented in the subject Inspection Report.

If you should have any questions or require further information, please contact Brenda DeMerchant, Oyster Creek Licensing Engineer at 609-971-4642.

Sincerely yours,

John J. Barton
Vice President and Director
Oyster Creek

JJB/BDE/jc
cc: Administrator, Region 1
Senior NRC Resident Inspector
Oyster Creek NRC Project Engineer

IE01

Attachment I

Violation

Technical Specification 6.8 (Procedures) states that written procedures shall be established, implemented, and maintained that meet or exceed the requirements of NRC Regulatory Guide 1.22, "Quality Assurance Program Requirements (Operation)," including procedures for performing maintenance.

C000-WMS-1220.08, "Job Order," requires that the job supervisor coordinate with the planner or job coordinator if the job scope changes and/or job order revisions are required.

Contrary to the above, during a repetitive maintenance activity (Job Order 56488) on September 25, 1994, and November 3, 1994, the job supervisor did not coordinate with the planner or job coordinator when work that was outside the scope of the job order was performed on two drywell ventilation exhaust valves V-27-1 and V-27-2. As a result, the appropriate post-maintenance test was not performed, and valves V-27-1 and V-27-2 were later determined to be inoperable.

GPUN Reply

GPUN concurs with the violation as written.

This occurance was also documented in Licensee Event Report (LER) 94-022 which was submitted to the NRC January 18,1995.

Reason for the Violation

The cause of the violation was a failure to follow established procedures for the control of maintenance activities. This was attributed to a less than adequate understanding by the maintenance personnel of the requirements related to changes in the scope of work that would have invoked additional work instructions and post maintenance testing requirements.

Contributing causes for the violation were inadequate verbal & written communication, attention to detail, and followup. The supervisors involved exercised poor judgement by not identifying the additional activities as a major scope change to the job order.

Corrective Actions Taken and the Results Achieved

Upon discovery of the deficient condition of the valves, immediate corrective actions were taken to obtain proper adjustment of the valve operators, and perform the appropriate post maintenance testing. Valve operability was established in compliance with Technical Specifications.

Corrective Steps Taken to Avoid Further Violations

A special GPUN Assessment Team comprised of personnel from various GPUN functions and with varied backgrounds including maintenance was convened at the request of the Director, Oyster Creek. A broad and comprehensive evaluation of the event was conducted including root cause determination and recommended corrective actions.

Attachment I (Continued)

Corrective Steps Taken to Avoid Further Violations (Continued)

Corrective actions were expeditiously implemented to assure maintenance personnel were fully aware of the event and the administrative requirements which apply to work scope changes. In parallel with the Assessment Team's investigation, a specific Maintenance critique of the event was conducted. Timely communication of information necessary to avoid any additional occurrences was completed. In addition, personnel not associated with this event were interviewed to gain further assurance that administrative controls are understood by others in the Maintenance organization.

Additional measures have been or will be taken to assure the event and lessons learned are fully understood by maintenance and station personnel:

- The Site Director provided written communications to all station personnel reaffirming his and the Company's expectations of compliance with Policies, Standards, and Procedures.

- The Plant Maintenance Director provided his review of the event, that of the Assessment Team and that of the Maintenance Critique, to each supervisor emphasizing managements expectation for compliance to procedural controls.

- Training of all maintenance craft personnel is underway to resensitize them to the importance of compliance to procedures, and the administrative requirements that apply to changes in the work scope for job orders. This training is expected to be completed by March 31,1995.

- The Plant Maintenance Director is conducting face to face discussions with each first line supervisor to discuss this event, the need to comply with procedures and to emphasize Maintenance Managements' expectations with regard to the ownership and accountability aspects associated with carrying out their job responsibilities.

Date When Full Compliance was Achieved

Full compliance was achieved on **December 19, 1994** when V-27-1, and V-27-2 were successfully adjusted, local leak rate tested, and stroked closed.