

JUN 8 1983

E.L. "MONTE" CONNER

PRIORITY ATTENTION REQUIRED

MORNING REPORT - REGION I
6-7-83

PRIORITY ATTENTION REQUIRED

TO: JAMES DEAN, CHIEF, PROGRAM SUPPORT BRANCH, IE
FROM: JAMES A. ALLAN, REGION I

LICENSEE/FACILITY NOTIFICATION/SUBJECT DESCRIPTION OF ITEMS OR EVENTS

DPAP

PEACH BOTTOM 6/6 SRI PHONE
UNITS 2 AND 3
SU-277/278

THE LICENSEE IS EXERCISING HIS EMERGENCY PLAN TODAY. LIMITED STATE, COUNTY AND LOCAL GOVERNMENT PARTICIPATION IS PLANNED. A FULL-SCALE EXERCISE IS SCHEDULED FOR 6/28.

UTZEL CREEK 6/6 LICENSEE ENS;
SU-219 6/7 SRI FAX

AT ABOUT 10:50 P.M., 6/6, CHLORINE GAS WAS RELEASED INTO THE ATMOSPHERE FOR ABOUT 12 MINUTES FROM A LEAK IN A 3/4" PLASTIC PIPE AT THE OUTLET OF THE CHLORINATOR EVAPORATOR. THE LICENSEE IDENTIFIED AND ISOLATED THE LEAK ABOUT 11:07 P.M. ALL PERSONNEL WERE ACCOUNTED FOR. AN UNUSUAL EVENT WAS DECLARED AT 11:17 P.M. AND 25 PERSONS REPORTED TO TWO AREA HOSPITALS FOR TREATMENT. ONE PERSON REMAINED HOSPITALIZED OVERNIGHT FOR OBSERVATION. ALL OTHERS WERE TREATED AND RELEASED. THE SENIOR RESIDENT INSPECTOR RESPONDED TO THE SITE. OSHA REGION 2 WILL BE NOTIFIED. PNO-I-83-56 ISSUED ON 6/7, DUE TO NRCIA INTEREST. THE PLANT IS IN AN EXTENSIVE REFUELING AND MODIFICATION OUTAGE.

CALVERT CLIFFS 5/6 ENS CALL
UNIT 1
SU-317

THE UNIT TRIPPED AT 7:44 P.M. DUE TO A PARTIAL LOSS OF FLOW FOLLOWING THE LOSS OF NO. 11A REACTOR COOLANT PUMP. THE RCP'S BREAKER HAD TRIPPED ON FAULT DUE TO A SHORTED SURGE SUPPRESSOR. ALL SYSTEMS FUNCTIONED NORMALLY FOLLOWING THE TRIP. RESTART IS PLANNED TODAY.

SUSQUEHANNA 6/7 SRI TTECON
UNIT 1
SJ-387

ABOUT 4 A.M., 6/7, THE LICENSEE FOUND THE HIGH REACTOR WATER LEVEL MAIN TURBINE TRIP BYPASSED AND RESET IT. THIS CONDITION APPEARS TO HAVE BEEN CAUSED BY FAILURE TO RESTORE MANUAL LINEUP AFTER TURBINE CONTROL VALVE TESTING DURING SHUTDOWN, REPRESENTING IMPROPER LINEUP SINCE ENTERING MODE 1 AT 2:48 P.M., 5/24. THE RESIDENT INSPECTOR IS REVIEWING THIS OCCURRENCE IN DETAIL.

DURING TESTING OF THE COMBINED INTERMEDIATE VALVES BETWEEN THE HP AND LP TURBINES, A HAD LIMIT SWITCH WAS FOUND TO BE PREVENTING CLOSURE OF TWO OF THE VALVES. POWER REDUCTION WAS INITIATED, THE CONDITION WAS CORRECTED WITHIN THE TS ACTION STATEMENT LIMIT (6 HRS.), AND POWER HAS BEEN RETURNED TO 95 PERCENT.

JUN 17 1983

Docket/License: 50-219/DPR-16

GPU Nuclear Corporation
ATTN: Mr. P. B. Fiedler
Vice President and Director
Oyster Creek Nuclear Generating Station
Forked River, New Jersey 08731

Gentlemen:

Subject: Inspection 50-219/83-14

This refers to the routine resident safety inspection by Messrs. C. Cowgill and J. Thomas on May 3 - June 8, 1983 at the Oyster Creek Nuclear Generating Station, Forked River, New Jersey. The inspection consisted of document reviews, interviews, and observation of activities. The findings were discussed with you and other members of your staff at the conclusion of the inspection.

Within the scope of this inspection, no violations were identified.

In accordance with 10 CFR 2.790(a), a copy of this letter and the enclosure will be placed in the NRC Public Document Room unless you notify this office, by telephone, within ten days of the date of this letter and submit written application to withhold information contained therein within thirty days of the date of this letter. Such application must be consistent with the requirements of 2.790(b)(1). The telephone notification of your intent to request withholding, or any request for an extension of the 10 day period which you believe necessary, should be made to the Supervisor, Files, Mail and Records, USNRC Region I, at (215) 337-5223.

No reply to this letter is required. Your cooperation with us in this matter is appreciated.

Sincerely original Signed By:

for R. R. Keising
Richard W. Starostecki, Director
Division of Project and Resident
Programs

Enclosure:

1. NRC Region I Report 50-219/83-14

REO1

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~~8301010011~~
PDR/LPDR

JUN 17 1983

cc w/encl:

- ✓ M. Laggart, Licensing Supervisor
- ✓ J. Knubel, BWR Licensing Manager
- Public Document Room (PDR)
- Local Public Document Room (LPDR)
- Nuclear Safety Information Center (NSIC)
- ✓ NRC Resident Inspector
- ✓ State of New Jersey

bcc w/encl:

- ✓ Region I Docket Room (with concurrences)
- ✓ Senior Operations Officer (w/o encls)
- DPRP Section Chief

S. NUCLEAR REGULATORY COMMISS. ↓

REGION I

Docket Nrs: 05000219-830327
05000219-830406
05000219-830418
05000219-830516
05000219-830606
05000219-830607

Report No. 83-14
Docket No. 50-219
License No. DPR-16 Priority -- Category C
License: GPU Nuclear Corporation
100 Interpace Parkway
Parsippany, New Jersey 07054

Facility Name: Oyster Creek Nuclear Generating Station

Inspection at: Forked River, New Jersey

Inspection Conducted: May 3 - June 8, 1983

Inspectors: Cowgill
C. Cowgill, Senior Resident Inspector

6/13/83

date signed

Thomas
J. Thomas, Resident Inspector

6/13/83

date signed

Approved by: E. L. Conner
E. L. Conner, Chief, Reactor
Projects Section 2D

6/16/83

date signed

Inspection Summary: Inspection on May 3 - June 8, 1983 (Report No. 50-219/83-14)
Routine inspection by the resident inspectors (144 hours) which included
followup of previous inspection findings, review of plant operations, log and record
review, plant tours, physical security, radiation protection, surveillance
observation, maintenance and refueling maintenance observation, followup of
onsite events, licensee event report review, attendance at licensee meetings,
review of IE Bulletins, and review of periodic and special reports.

Results: No Violations

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~~8301010025~~
PDR/LPDR

DETAILS

1. Persons Contacted

J. Brownridge, Maintenance and Construction Jobs Manager
M. Budaj, Manager, Plans and Programs
P. Fiedler, Vice President, Director, Oyster Creek
V. Foglia, Manager, Operational Corrective Maintenance/Preventive Maintenance
E. Growney, Safety Review Manager
M. Laggart, Manager, Oyster Creek Licensing
B. Leavitt, Deputy Manager, Radiological Controls
J. Maloney, Manager, Plant Materiel
J. Maughn, Supervisor, Security
R. Mc Keon, Manager, Plant Operations
W. Smith, Plant Engineering Director
W. Stewart, Operations Control Manager
J. Sullivan, Plant Operations Director
D. Turner, Manager, Radiological Controls

2. Review of Previous Inspection Findings

(Closed) Violation (83-04-01) Failure to conduct adequate search. During normal access to and egress from both the north and main entrances to the site protected area, the inspectors have routinely observed search procedures. All packages except those containing liquids, are now required to be processed through X-ray machines. During these observations, no search violations have been identified.

(Closed) Violation (83-04-02) Violation of Security Procedures for Personnel Escort. The licensee took immediate corrective action to place the subject visitor under escort and to correct the deficient performance of the individual who had been assigned to escort duty. The licensee's current procedures for visitor control are adequate. The requirements have been reemphasized and the violation discussed with all departments.

The inspector had no further questions on this item.

(Closed) Violation (83-08-01) Failure to properly control access to vital areas. The inspector has observed control at selected vital area access points during routine plant tours and has noted that site protection force personnel are posted as required, and appropriate log entries are made when required. The vital area locking devices discussed in the licensee's letter dated June 6, 1983 have been installed.

No unacceptable conditions were identified.

3. Plant Operations Review

3.1 Shift Logs and Operating Records

Shift Logs and Operating Records were reviewed to verify that they were properly completed and signed and had received proper supervisory reviews. The inspectors verified that entries involving abnormal conditions provided sufficient details to communicate equipment status and followup actions. Logs were compared to equipment control records to verify that equipment removed from or returned to service was properly noted in operating logs when required. Operating memos and orders were reviewed to insure that they did not conflict with Technical Specification requirements. The logs and records were compared to the requirements of Procedure 106, "Conduct of Operations", and Procedure 108, "Equipment Control". The following were reviewed:

- Control Room and Group Shift Supervisor's Logs;
- Control Room, and Shift Supervisor's Turnover Check List;
- Control Room Shutdown Log;
- Reactor Building and Turbine Building Tour Sheets;
- Standing Orders;
- Operational Memos and Directives.

No unacceptable conditions were noted.

3.2 Facility Tours

The inspectors frequently toured the following areas:

- Control Room (daily)
- Reactor Building
- Turbine Building
- Augmented Off-Gas Building
- New Rad-Waste Building
- Cooling Water Intake and Dilution Plant Structure
- Monitor and Change Area

- 4160 Volt Switchgear, 460 Volt Switchgear, and Cable Spreading Room
- Diesel Generator Building
- Battery Rooms
- Maintenance Work Areas
- Yard Areas (including Protected Area Perimeter)

The following were observed:

- 3.2.1 During daily control room tours, the inspectors verified that the control room manning requirements of 10 CFR 50.54(k), Technical Specifications and the licensee's conduct of operations procedure were met. Shift turnovers were observed for adequacy. Selected control room instrumentation needed to support the cold shutdown conditions was verified to be operable and indicated parameters within normal expected limits. Recorders were examined for evidence of abnormal or unexplained transients. Plant stack radiation recorder traces were examined for evidence of abnormal or unplanned releases of radioactive gases. The inspectors verified compliance with Technical Specification Limiting Conditions for Operation (LCO's) applicable to the cold shutdown condition and refueling activities, including those relating to primary and secondary containment integrity, and fire protection systems. The inspectors closely monitored outage activities and verified that operators and supervisors were aware of work in progress and complied with applicable Technical Specification requirements.

No unacceptable conditions were identified.

- 3.2.2 Selected alarmed annunciators were discussed with control room operators and supervisors. A large number of annunciators were in an alarmed condition because of systems being shutdown or drained and layed up to support outage related maintenance activities. The inspectors verified that operators were knowledgeable of system status and were aware of which alarms were indicative of abnormal conditions requiring followup and corrective action. The inspectors noted that the annunciator and alarm panels will be removed from service for system modification during this outage. A temporary alarm panel is being installed to provide those alarm indications needed to support the plant's cold shutdown, defueled condition. The inspectors will monitor the installation and examine the temporary system for adequacy.

No unacceptable conditions were identified.

- 3.2.3 The inspectors verified the operability of selected systems considered important to safety by direct observation of valve, breaker, and switch position. Components were examined for leakage, proper lubrication, operating air supply, and general conditions. Selected pipe hangers and seismic restraints were examined for indications of mechanical interference and fluid leaks. Systems inspected included Control Rod Drive Hydraulic, Standby Gas Treatment, and portions of the 4160 and 460 volt electrical distribution systems.

On May 17, 1983, the inspector noted an oil leak on the outboard bearing of the 'D' Augmented Spent Fuel Pool Pump. The inspector informed the operations department and determined that the leak had been identified by the operators, maintenance actions initiated, and steps taken to closely monitor the pump while it was operating pending repairs.

No unacceptable conditions were identified.

- 3.2.4 Equipment Control procedures were examined for proper implementation by verifying that tags were properly filled out, posted, and removed as required, that jumpers were properly installed and removed, and that equipment control logs and records were complete. Selected active tagouts were independently verified by the inspectors. Selected cleared tagouts were reviewed to determine that system alignments had been properly restored and safety systems returned to service had been properly tested. Selected locked valves were examined for proper position and installation of locking devices. The inspectors monitored outage related activities including erection of scaffold and work platforms, installation of temporary hoses and cables, and the set up of radiological control barriers, to ensure that these activities did not block or otherwise impair the operability of components important to safety, and were controlled in accordance with the equipment control procedures when required.

No unacceptable conditions were identified.

- 3.2.5 The inspectors examined plant housekeeping conditions including general cleanliness, control of material to prevent fire hazards, maintenance of fire barriers, storage and maintenance of fire fighting equipment, and radiological housekeeping.

At about 10:30 P.M. on May 31, 1983, there was a minor fire in the torus. A fault on an energized welding lead caused an electrical arc which burned the insulation on the welding lead cable. The arcing was seen by the fire watch who extinguished the fire by deenergizing the cable. There was only minor smoke, no personnel injuries, and no damage. No fire brigade response was needed.

The faulted welding lead was replaced and other leads were inspected for possible insulation degradation.

No unacceptable conditions were identified.

4. Radiation Protection

During entry to and exit from radiation controlled areas (RCA), the inspectors verified that proper warning signs were posted, personnel entering were wearing proper dosimetry, that personnel and materials leaving were properly monitored for radioactive contamination and that monitoring instruments were functional and in calibration. Posted Radiation Work Permits (RWP's) and survey status boards were reviewed to verify that they were current and accurate. The inspector observed activities in the RCA to verify that personnel complied with the requirements of applicable RWP's and that workers were aware of the radiological conditions in the area. Particular attention was given to activities around the control points on the refueling floor, the drywell entry, the torus access point, and the turbine operating floor. In general, health physics technicians manning the control points and monitoring activities within the RWP areas were very knowledgeable of the radiological working conditions and were well abreast of outage activities in progress and planned for their assigned areas. They assured that people entering the areas were apprised of the radiological conditions and that proper protective measures were taken.

No unacceptable conditions were identified.

5. Physical Security

During daily entry and egress from the protected area, the inspectors verified that access controls were in accordance with the security plan and that security posts were properly manned. During facility tours, the inspectors verified that protected area gates were locked or guarded and that isolation zones were free of obstructions. The inspectors examined vital area access points to verify that they were properly locked or guarded and that access control was in accordance with the security plan. Vehicles onsite were periodically observed to verify proper controls. Visitors onsite were observed to verify that security plan escort requirements were met.

No unacceptable conditions were identified.

6. Maintenance and Surveillance Testing

The inspectors observed maintenance and surveillance activities to verify that activities were properly approved, operations personnel were cognizant of activities in progress, proper procedural controls were in effect, redundant systems and components were available when required, test instrumentation was calibrated, activities were performed in an acceptable manner by appropriately qualified personnel, and material and replacement parts were properly controlled. The following procedures were reviewed:

- Procedure 756.1.003, revision 4, November 30, 1982, Shield Plugs Removal and Replacement.

- Procedure SP 83-045, Installation and Removal of Recirculation Outlet Nozzle Shield Curtains.
- Procedure 205.98, revision 0, April 26, 1983, Reactor Vessel Draining Procedure.

No unacceptable conditions were identified.

Review of maintenance activities included direct observation of the performance of portions of the evolution, observation of work crew briefings, reviews of the planning of the evolution, and reviews of the radiological precautions. Portions of the following activities were observed:

- Construction activities in the new cable spreading room.
- Torquing of anchor bolts on new cable tray supports.
- Feedwater system flow control valve rebuild.
- Reactor feed pump maintenance.
- Control Rod Drive Hydraulic pump rebuild.
- Turbine Building Closed Cooling Water system modification.
- Turbine disassembly, inspection, and reassembly.

No unacceptable conditions were identified.

7. Emergency Preparedness Drill and Exercise Observations

On May 4 and 10 the licensee conducted emergency plan exercises in preparation for the NRC/FEMA observed exercise on May 24, 1983. Each exercise implemented all phases of the site emergency plan. On both occasions, the State of New Jersey participated. The inspector observed selected portions of each exercise including control room, Technical Support Center and Near Site Emergency operating facility activities. The inspector noted that exercise objectives were met in each case. He also provided comments to utility management.

On May 24, 1983, the inspectors participated as members of the NRC observation team for the full scale observed exercise. The exercise activated all levels of the site emergency plan and included participation by State and local officials. Inspector observations of this exercise will be included in NRC inspection report 50-219/83-15.

8. Inspector Attendance at Significant Licensee Meetings.

8.1 Systematic Assessment of Licensee Performance (SALP)

On May 12, 1983, NRC met with licensee representatives to discuss the results of the Regional SALP assessment of GPU Nuclear Oyster Creek for the period February 1, 1982 through January 31, 1983. The meeting provided open discussion of the assessment as well as licensee plans for improvements in the next period. The results will be forwarded in NRC inspection report 50-219/83-16.

8.2 Post-Accident Sampling System (PASS)

On May 12th, NRC representatives from NRC Region I and the Office of Nuclear Reactor Regulation met with the licensee regarding completion of NUREG 0737, Item II.B.3 Post-Accident Sampling. During the meeting, the following agreements were reached and confirmed by the licensee in a letter to NRC:NRR dated May 20, 1983.

- Complete installation work requiring reactor shutdown during the current refueling outage.
- The PASS will be fully operational 6 months following completion of the current refueling outage.
- Alternate methodology developed that estimates extent of post-accident core degradation.

The inspectors will follow licensee progress on completion of the PASS.

9. Review of Licensee Event Reports (LER's)

- 9.1 The inspector reviewed LER's submitted to NRC:R1 to verify that the details were clearly reported, including the accuracy of the description and corrective action adequacy. The inspector determined whether further information was required, whether generic implications were indicated, and whether the event warranted onsite followup. The following LER's were reviewed:

<u>LER</u>	<u>SUBJECT</u>
83-07	Standby Gas Treatment System II was declared inoperable and removed from service for HEPA filter replacement.
83-13	Both doors of one reactor building personnel access airlock were open simultaneously due to personnel error.

*83-14

Design deficiency in Standby Gas Treatment System filter heater control circuit.

- 9.2 For those LER's selected for on-site followup, the inspector verified that reporting requirements of Technical Specifications and Regulatory Guide 1.16 had been met, that appropriate corrective action had been taken, that the event was reviewed by the licensee as required by facility procedures, and that continued operation of the facility was conducted in accordance with Technical Specification limits. The LER's selected for on-site followup are denoted by an asterisk (*) in detail 9.1 above.

- 9.2.1 Licensee Event Report 83-14 reported a design deficiency in the Standby Gas Treatment System (SGTS) heater control circuit which could have impaired the operation of SGTS II filters if during an accident situation Diesel Generator 1 failed while SGTS II was in operation. Electric heaters are installed in the redundant filter trains to reduce the relative humidity of the incoming air stream. The SGTS I is powered from the number 1 Diesel Generator Bus and system II is powered from the number 2 Diesel Generator Bus. However, both systems' heater control circuits are powered from the number 1 Diesel Generator Bus. Thus, the high humidity that may result from heater failure caused by a loss of number 1 Diesel Generator could reduce the systems' filter efficiencies. The licensee took immediate corrective action to install a temporary power supply from number 2 Diesel Generator Bus to the heater control circuit for SGTS II. A permanent modification will be installed during the current outage. This event is under review by NRC headquarters for potential generic implications.

The inspectors had no further questions on this item.

10. Followup of Events That Occurred During the Inspection

- 10.1 On May 16, 1983, a rotor assembly from a contaminated pump was being transported in a licensee owned vehicle to Three Mile Island Nuclear Station for dynamic balancing. The vehicle was involved in an accident about 3.5 miles south of the plant when it was struck broadside by another vehicle that failed to stop at a traffic light. The pump rotor, which had fixed radioactive contamination of 200 to 400 counts per minute and a total activity of 0.08 microcuries, was packaged in a heavy wooden crate and was undamaged in the accident. The inspector went to the scene of the accident with a licensee health physics technician and a licensee health physics supervisor. Contact radiation measurements and smear surveys of the package showed no levels above background and no release of radioactive material. The package was returned to the site, inspected, repackaged, and shipped on to its original destination. There

were no personnel injuries and no radiological hazards resulting from the accident. The licensee's actions were prompt and proper.

The inspectors had no further questions on this item.

- 10.2 Late on June 6, 1983, chlorine gas was released into the atmosphere when a one-half inch plastic pipe (poly vinyl chloride) in the outlet of the chlorinator evaporator ruptured. The leak was identified and isolated about 11:07 P.M.. Licensee declared an unusual event at 11:17 P.M. and made all appropriate notifications.

Due to the nature of the event, station accountability was ordered and all persons onsite at the time (approximately 500) were mustered at remote assembly areas and accounted for shortly after midnite. One person was transported to a local hospital via ambulance and remained overnite for observation. Several others were examined and released.

Licensee representatives conducted a thorough site tour and the event terminated about 2 A.M. on June 7th. The inspector reviewed licensee actions and identified no unacceptable conditions.

Licensee investigation of this event determined that the failed PVC piping is incompatible with the chlorine at the temperatures and pressures (150°F and 150 psig) to which it was exposed. Alternative materials are being evaluated and the inspectors will follow the licensee's corrective action on this item.

- 10.3 About 2 P.M. on June 7, 1983, an individual was injured during a tour of the drywell when a heavy bag (approximately 25 pounds) of used insulation fell on him. He was removed from the drywell and transferred to a local area hospital for treatment. He was transferred as potentially contaminated due to the nature of his injury. Later licensee surveys determined that no contamination was present. Licensee declared an unusual event and made appropriate notifications. The inspector reviewed licensee actions and identified no unacceptable conditions.

11. Review of IE Bulletin 79-09

Bulletin 79-09, Failures of GE Type AK-2 Circuit Breakers, was issued in April 1979 to warn of failures of the subject breakers to trip due to binding of the linkage of the undervoltage trip device and trip shaft assembly. The licensee responded to the bulletin on May 17, 1979, stating that the requirements of the bulletin and the referenced GE Service Advise Letter (SAL) 175 (CPDD) 9.3 had been implemented. The actions were reviewed and documented in NRC Inspection 50-219/79-14. Type AK-2 breakers are used at Oyster Creek in the 480 volt power supplies to Core Spray Booster pumps, Containment Spray pumps, Service Water pumps, and Control Rod Drive pumps. During preparations for preventive maintenance on these breakers during the current refueling outage, the licensee found that all of the bulletin requirements had not been implemented.

The bulletin referred to the GE SAL which required that the torque required on the trip shaft to trip a closed breaker be checked and should not exceed 1.5 pounds - inches. This requirement had not been incorporated into procedure 761.2.003, "480 Volt Breaker Preventive Maintenance". Following the licensee's identification of this deficiency, he notified the resident inspector, added the requirement to the preventive maintenance check lists, and initiated action to change the maintenance procedure. The torque checks were performed on the trip shafts of the breakers in question and no abnormal operation was noted.

The inspectors had no further questions on this item.

12. Review of Periodic Reports

Upon receipt, periodic and special reports submitted by the licensee pursuant to Technical Specification 6.9.1 were reviewed by the inspector. This review included the following considerations: the report includes the information required to be reported to the NRC; planned corrective actions are adequate for resolution of identified problems; and that the reported information is valid. Within the scope of the above, the following periodic reports were reviewed by the inspector.

-- April 1983 Monthly Operating Report

No unacceptable conditions were identified.

13. Exit Interview

At periodic intervals during the course of this inspection, meetings were held with senior facility management to discuss inspection scope and findings. A summary of findings was presented at the conclusion of the inspection.