



Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038

Nuclear Department

May 24, 1984

Regional Administrator, Region I
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Attention: Mr. Richard W. Starostecki, Director
Division of Project and Resident Programs

Gentlemen:

SUPPLEMENTAL RESPONSE
NRC COMBINED INSPECTION 50-272/84-08 AND 50-311/84-08
SALEM GENERATING STATION
NO. 1 AND 2 UNITS
DOCKET NOS. 50-272 AND 50-311

During the subject inspection, conducted on February 7 through March 6, 1984, a violation was identified relating to failure to follow an Operating Instruction. Our response to the Notice of Violation appended to your letter dated March 26, 1984, was submitted by letter dated April 27, 1984. As a result of subsequent discussions with the Salem Senior Resident Inspector, a supplemental response is provided below:

ITEM OF VIOLATION:

Technical Specification 6.8.1 requires that written procedures be maintained covering applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2, February 1978. Appendix "A" of Regulatory Guide 1.33 requires written procedures for the startup of the shutdown cooling system.

Contrary to the above, at 12:45 p.m. on February 8, 1984, Operating Instruction II.6.3.2, Initiating RHR, was not maintained, in that the hot leg isolation valve, 2RH26, was opened rather than 21SJ49 and 22SJ49, the discharge valves to the cold legs, as required by step 5.16 of the operating instruction.

REPLY TO ITEM OF VIOLATION:

On February 6, 1984, Performance Surveillance Procedure 4.4.7.2.1 was initiated to check for leakage from the Reactor Coolant System (RCS) Pressure Isolation valves. During the performance of this surveillance activity, it was found that 22SJ56

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"Safety Injection Discharge to #22 RCS Cold Leg Check Valve" was leaking. As a result, Action Statement 3.4.7.2c was entered and testing was continued in order to identify any other check valves which may have been leaking. RCS pressure and temperature were reduced to 1200 psig and 500°F respectively. An attempt to flush the seat of 22SJ56 by injecting water through the valve using a Safety Injection Pump was performed. On February 7, 1984, Surveillance Procedure 4.4.7.2.1 was again performed. The results indicated that leakage still existed on 22SJ56. Due to the action statement requirement to be in Cold Shutdown within 30 hours after the discovery of the leakage, a plant cooldown was commenced and Mode 5 was entered at 1948 hours. Due to the limited testing of the other Reactor Coolant System Pressure Isolation valves, and the suspicion that some of these might also be leaking; a method of testing these check valves with the unit in Mode 5 was developed. This method of testing involved the closure of 21SJ49 and 22SJ49 (RHR Discharge to Cold Legs), and the opening of 2RH26 (RHR Discharge to Hot Legs). It also required some modifications to SP(O)4.4.7.2.1. On February 8, 1984, a temporary "On-The-Spot-Change" was made to the Surveillance Procedure. The change to the Surveillance Procedure required that the Residual Heat Removal System needed to be in a Hot Leg to Hot Leg circulation mode in order to perform the test. It was decided by Station management that this was a preferable way to operate, as heating up and cooling down to test and fix each of the check valves in question would have caused undue stress on the system. This decision was based on discussions which included Technical Specification limitations, cooling capability of this arrangement, residual decay heat removal, boron stratification considerations, and Reactor Coolant System flow characteristics. However, the need to perform a formal safety evaluation, in accordance with 10 CFR 50.59, was overlooked. When the testing was completed, and the leaking Reactor Coolant System Pressure Isolation valves were identified, it was decided to leave the Residual Heat Removal System in the Hot Leg to Hot Leg circulation mode of operation until subsequent repairs and testing were completed. Due to an oversight, the required changes to the particular Operating Instruction were not made, even though the specific Surveillance Procedure had been changed and the consequences of the actions analyzed.

CORRECTIVE STEPS WHICH HAVE BEEN TAKEN AND RESULTS ACHIEVED:

An "On-The-Spot Change" was subsequently made to the operating instruction for RHR (OI II.6.3.2) and a Safety Evaluation was performed which confirmed minimal safety significance. It is recognized that the "On-The-Spot-Change" does not provide the review process necessary to perform a change of this nature. An Information Directive was issued to all licensed operators

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reemphasizing that when methods of operation outside normal established and approved procedures are contemplated, all procedures and instructions applicable to that system or task shall be reviewed to determine if operation in the proposed manner potentially involves an unreviewed safety question or constitutes operation outside of parameters analyzed in the UFSAR or delineated in the Technical Specifications. If it is determined that the method proposed is not within approved procedures, prior to placing the unit in the proposed configuration, a procedure change and safety evaluation shall be performed.

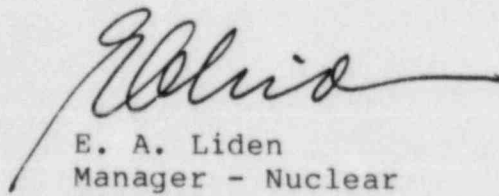
CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS:

An evaluation will be conducted to identify an improved mechanism for conducting 10 CFR 50.59 reviews.

DATE FOR FULL COMPLIANCE:

We are now in full compliance.

Sincerely,



E. A. Liden
Manager - Nuclear
Licensing and Regulation

Attachment

C Director, Office of Inspection and Enforcement
Nuclear Regulatory Commission
Washington, D.C. 20555

Mr. Donald C. Fischer
Licensing Project Manager

Mr. James Linville
Senior Resident Inspector

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