

ENCLOSURE 2

Report No. 50-219/84-19

U. S. NUCLEAR REGULATORY COMMISSION
REGION I

SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE
GPU NUCLEAR CORPORATION
OYSTER CREEK NUCLEAR GENERATING STATION
JUNE 21, 1984

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1.0 INTRODUCTION

1.1 Purpose and Overview

The Systematic Assessment of Licensee Performance (SALP) is an integrated NRC staff effort to collect the available observations on an annual basis and evaluate licensee performance based on those observations with the objectives of improving the NRC Regulatory Program and Licensee performance.

The assessment period is February 1, 1983 to April 30, 1984.

- 1.2 SALP Board Members:
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 - R. Vollmer, Director, Division of Engineering, NRR
 - R. Bellamy, Chief, Radiological Protection Branch, Division of Engineering and Technical Programs.
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 - E. Conner, Section Chief, Section 3B, Division of Project and Resident Programs
 - C. Cowgill, Senior Resident Inspector, Oyster Creek Nuclear Generating Station.

Other Attendees: J. Wechselberger, Resident Inspector, Oyster Creek Nuclear Generating Station.

1.3 Background

(1) Licensee Activities

At the beginning of the assessment period, the facility was operating at 239 MWe with load limited by core reactivity. The reactor was shutdown February 12, 1983 for the planned 1983 refueling and maintenance outage and has remained shutdown for this outage during the entire assessment period.

During the outage, 75 major modifications were scheduled for accomplishment. As of the end of the evaluation period, over 5000 individual maintenance activities have been completed. Some of the significant modifications and repair activities completed were:

- Repair of cracks in recirculation valve discs;
- Recirculation pump seal replacement;
- Feedwater system valve repairs;
- Reactor Protection System HFA relay replacement;
- Scram discharge volume modifications;
- Installation of plant computer and emergency response facility data system;
- Construction of site building for Technical Support Center;
- Torus modifications and painting;
- Installation of post accident sampling system and chemistry laboratory expansion;
- Intermediate range monitor range expansion (10 ranges);
- Addition of new cable spreading room; and
- Turbine inspection.

The licensee inspection of the core spray sparger and vessel annulus was completed in March 1983. The reactor recirculation piping was completed during the month of July 1983. No cracking identified in either system.

The licensee satisfactorily completed an annual emergency plan exercise on May 24, 1983. The exercise was observed by a Region I inspection team.

On June 6, 1983, an unusual event was declared when a chlorine leak occurred in the plant's chlorination system. The leak was isolated in eleven minutes. The unusual event was terminated following the satisfactory accountability of station personnel.

A fire occurred in the step down transformer for substation bus "A" on November 14, 1983. This resulted in a complete loss of offsite power. The fire brigade and local fire companies responded. The potential transformer was replaced and the electric plant was placed in a normal shutdown lineup.

An Intermediate Range Monitor (IRM) dry tube was discovered to be cracked in February. Additional inspection found a total of 8 dry tubes (7 IRM and 1 SRM) to be cracked. The facility has formulated replacement plans to be conducted prior to restart.

Twenty-seven crack indications have been found in the condensate and steam lines outside the drywell for the two isolation condensers. An inspection of the piping was conducted by the licensee as a result of discovering a leak in a condensate line during a system hydrostatic test. The licensee repair plans include pipe replacement and weld overlaying. These repairs will be completed prior to plant restart.

(2) Inspection Activities

A Senior Resident Inspector was assigned to the site for the entire assessment period. A second Resident Inspector was on site from February 1 to September 1, 1983 and since January 1, 1984.

Two team inspections were performed during the evaluation period. One team reviewed licensee actions in response to two consultant reports (BETA and RHR) and the 1982 INPO evaluation. A second team evaluated readiness for operations following the long refueling and maintenance outage. This team reviewed the modification process used to control outage work.

The total NRC Region I inspection hours (resident and region-based) for this assessment period is 3,643 hours.

2.0 SUMMARY OF RESULTS

OYSTER CREEK NUCLEAR GENERATING STATION

FUNCTIONAL AREAS	CATEGORY	CATEGORY	CATEGORY
	<u>1</u>	<u>2</u>	<u>3</u>
1. Plant Operations and Outage Control	X		
2. Radiological Controls	X		
• Radiation Protection			
• Radioactive Waste Management			
• Transportation			
• Effluent Control and Monitoring			
3. Maintenance		X	
4. Surveillance (Including Inservice and Preoperational Testing)	X		
5. Fire Protection and Housekeeping		X	
6. Emergency Preparedness		X	
7. Security and Safeguards		X	
8. Outage Technical Support		X	
9. Licensing Activities		X	

Overall Assessment

This assessment is based on licensee performance during an extended refueling and modification outage. Major efforts were expanded by the licensee to upgrade plant equipment as well as perform modifications to plant systems. During the outage, about 75 modifications and over 5000 corrective maintenance items were performed in addition to required testing and inspection. Many nonroutine evolutions were performed and evaluation of these evolutions showed involvement by all site organizations including QA and QC. Overall activities were conducted in a technically competent manner.

In the area of Design Control a number of interface problems between the licensee and contract architect engineers were identified that had the potential for final designs to be inadequate. Additionally, constructability reviews during design needs improvement.

Overall, the licensee is devoting considerable resources to improve performance in all areas evaluated. Continued management attention to identifying and correcting weaknesses is apparent. Management commitment to safety is evident from commitment to training and high regard for stringent procedural adherence.

3.0 CRITERIA

The following performance aspects were reviewed in each area:

- Management involvement in assuring quality.
- Resolving technical issues from a safety viewpoint
- Responsiveness to NRC initiatives.
- Enforcement history.
- Reporting and analysis of reportable events.
- Staffing (including management).
- Training effectiveness and qualification.

To provide a consistent evaluation of licensee performance, attributes relating each aspect to the characteristics of Category 1, 2, and 3 performance were applied as discussed in NRC Manual Chapter 0516, Part II and Table 1.

The SALP Board conclusions were categorized as follows:

Category 1: Reduced NRC attention may be appropriate. Licensee management attention and involvement are aggressive and oriented toward nuclear safety; licensee resources are ample and effectively used such that a high level of performance with respect to operational safety is being achieved.

Category 2: NRC attention should be maintained at normal levels. Licensee management attention and involvement in nuclear safety are evident; licensee resources are adequate and reasonably effective such that satisfactory performance with respect to operational safety is being achieved.

Category 3: Both NRC and licensee attention should be increased. Licensee management attention or involvement is acceptable and considers nuclear safety, but weaknesses are evident; licensee resources appear strained or not effectively used such that minimally satisfactory performance with respect to operational safety is being achieved.

4.0 PERFORMANCE ANALYSIS

4.1 Plant Operations and Outage Control (21%)

This assessment is based on inspection of plant operation activities by the resident inspectors and region based inspectors. The inspectors reviewed compliance with technical specification requirements, training requirements, quality assurance audits, corrective action systems, safety review committee actions, and reporting system controls.

Management control of the outage throughout this assessment has been very good. There was continued evidence of management involvement in daily plant activities including daily control room tours by operations and support group managers, daily meetings involving operations, maintenance, and engineering department representatives, and publication of planned activities (three day periods). Observation of shift turnovers indicated that even during periods of relatively low operational activity shift turnovers were thorough, comprehensive and professional. Additionally, site quality assurance reviewed all ongoing activities in the operations areas.

The licensee has well established policies governing plant operations. These policies were widely distributed and generally well understood by plant operators and supervisors. Managements approach to activities was generally conservative and strongly safety oriented.

Control of outage activities was enhanced by the issuance of a daily plan of activities and close coordination of the various departments activities by a daily outage meeting. Senior management involvement was evident in this process through the approval of all daily activity plans. Although overall control of activities was acceptable there were significant interface problems early in the outage including, in some cases, inadequate job planning. Coordination improved as the outage progressed but interfacing between departments continued to be one of the most significant outage problems. However, no resultant safety problems were identified.

Many operational activities conducted during the assessment period were in support of major outage activities. In most cases, these activities were nonroutine and were governed by special procedures written specifically for that activity. Examples include reactor vessel draining and refilling, and refueling the reactor vessel with the suppression pool empty. The procedures were conservative, had received thorough management review and required the performance of periodic management checks at critical stages. The licensee performed a formal refueling certification prior to start of reactor vessel refueling. The inspector's review of this certification showed it to be comprehensive and properly reviewed by the licensee.

Control of refueling activities has been good. Core off load was observed by the NRC and procedures were judged to be comprehensive and conservative. The inspector observed good supervisory control. Observations of new fuel inspections showed that persons performing the inspections were thorough, knowledgeable and conservative. One problem associated with fuel movement occurred when a fuel bundle was dropped a few feet to the bottom of the fuel storage pool rack. Licensee corrective actions included placing a camera on the fueling grapple to insure proper latching of the bundles. The inspection of fuel loading activities showed that personnel were well trained and properly supervised.

The licensee's response to abnormal conditions has been excellent. Early in the assessment period a chlorine leak resulted in declaration of an unusual event. Operator and station management response was prompt and thorough. In November, during a loss of offsite power, the licensee's response demonstrated their safety orientation and senior management involvement in site problems.

The Plant Operations Review Committee has been effective in reviewing safety issues. During the previous assessment period, a large backlog of items needing review was identified. The licensee augmented the review committee and conducted daily reviews until the backlog was reduced. Recent changes to the technical specifications have changed the review process and should help reduce future problems in this area. An additional technical specification change, involving the requirement to review temporary procedure changes within 14 days will require continued licensee attention since significantly more time than this has been required in some cases.

Licensee procedural control is acceptable. Inspector reviews showed that procedures are generally technically adequate and are capable of being performed as written. Some inadequacies have been identified by both licensee and NRC inspections involving missing valves in system valve checkoff lists. The missing valves were principally vent and drain valves. The licensee had, prior to NRC identification of the above problem, initiated a complete review of plant systems to verify accuracy of system components and drawings. This program includes verifying as built conditions for both mechanical and electrical systems and then correcting system checkoff lists. The program is scheduled to be completed by February 1985. One problem remains with regard to central control and accountability of temporary changes to procedures. Current procedures require that a log of temporary changes that are also to be made a permanent change be maintained in the control room. The inspector found no method of assuring that such temporary changes are maintained in a central location. Management attention to solve this problem was requested at the exit meeting.

Site Engineering support was well organized and adequately staffed. Engineering requests, from other groups were prioritized and tracked.

The inspector found that engineering evaluations were thorough and in most cases timely. Corporate plant engineering interfaces appear adequate but still require more coordination. The technical content of Licensee Event Reports (LER) continues to be excellent with good narrative descriptions, documentation of cause descriptions, and root cause determinations. Corrective actions are considered appropriate and well described. Timeliness of LER's continues to be a problem. A number of LERs have been submitted late and in some cases, extended periods of time pass before the decision is made that an event is reportable. Management attention to improve timeliness is necessary.

Site training programs for general employee access, operator training and engineering personnel were well established programs. The licensee expended considerable effort to upgrade all of the above programs. In particular site engineering personnel received significant system training. Also, operator requalification training has been upgraded as a result of the poor results achieved on the most recent licensee annual requalification examination.

Operator training for initial NRC licensee examinations has improved with 13 of 15 candidates for RO or SRC licenses passing during the reporting period. NRC examiners have been especially impressed with some SRO candidate performances on oral examinations. These examples demonstrate strong management support and attention to training and qualification.

Summary

During this assessment period, continued improvement has been observed in management control and review of operations function and site training activities. Substantial improvement has been noted in the chemistry area. Control of temporary changes and timeliness of event reporting continues to be a problem.

Conclusion

Category 1

Board Recommendations

Due to the length of the current outage, the Board recommends augment inspection coverage during plant startup. Maintain 16 hour coverage for about 4 weeks after startup. Return to normal coverage after that time.

4.2 Radiological Controls (9%)

There were seven routine inspections by radiation protection specialists during the assessment period. The Resident Inspectors on a continuing basis reviewed selected program areas. Two severity V violations were identified; one in effluent monitoring and one involving transportation. A continuing trend of improvement in the overall radiation safety program was noted this period. Significant improvements have been noted in plant chemistry.

4.2.1 Radiation Protection

The licensee's performance during the refueling outage has been commendable. For instance, the use of a specially designed containment to enclose contaminated components on the refueling floor greatly improved contamination control allowing access into this area in street clothes. A training program has been developed for workers who install these containments as well as for personnel who work inside the enclosures. Similar uses of containments during routine operation has allowed a gradual reduction of the square footage of contaminated area in the plant.

All managers within the Radiological Controls (RC) Department are permanent GPUN employees. Contractor personnel are used for a limited number of technician and technician supervisor positions. Job descriptions and delineation of responsibilities is clear. The organization has been stable with minimal turnover and no reorganization. Within the RC Department the responsiveness to NRC initiatives has been prompt and thorough.

The Operational Health Physics technicians play a key role in the control of work during the outage. Their excellent performance is the result of extensive training and qualification provided on the site. Each technician must complete a program that is similar to a licensed position, i.e., classroom instruction, practical factors, written exams, oral exams and experience prerequisites.

Radiological engineering reviews all "unusual incidents" (Internal report of events involving radiological controls). Each incident report resolution receives senior level management concurrence. Enforcement of radiological controls is strict and violations usually result in strong disciplinary action.

The inspectors found that the training of Support Technicians, those who perform whole body counts, issue dosimetry, and test respirator users, was not formalized. The licensee has subsequently developed a program and standardized it throughout the GPUN system.

Several minor problems were noted with radiation protection procedures. These findings were considered to be isolated and not indicative of a programmatic problems.

4.2.2 Radioactive Waste Management

Examination of the licensee's plans for implementation of land disposal of radioactive waste regulations indicated that the licensee has a clear understanding of the requirements of the new regulatory requirements (10 CFR 61). The licensee's implementation was timely and technically sound.

4.2.3 Transportation

The licensee has implemented a strong radioactive transport management organization. Procedures clearly define responsibilities and authorities of the Manager-Radwaste Operations and the Radwaste Shipping Supervisor. In addition, the responsibilities of other support groups are specified.

One transportation violation was identified involving failure to verify that the drain line and access plugs of a shipping cask were appropriately plugged and sealed prior to transport. The licensee immediately obtained confirmation that the package drain line and access plugs had been in compliance and implemented corrective actions to assure that future shipments would be in compliance. This violation was not considered indicative of programmatic defects.

A defined program of comprehensive training to key personnel involved in the transfer, packaging and transport of radioactive material is implemented as required. The review of the program indicates that the licensee is implementing a generally adequate and effective Radioactive Transportation Program.

4.2.4 Effluent Monitoring and Controls

Compared to the last assessment, the radio chemistry program has significantly improved. A new chemistry manager has been onsite for the entire evaluation period. Several additional persons have been added to the chemistry staff that have significant experience in radio chemistry. During this period, the licensee has revised all procedures and added internal laboratory QC controls. Significant improvements have been made in chemistry training and qualification. The licensee is constructing a new chemistry laboratory that should be in operation by October 1, 1984. On a quarterly basis, chemistry management now internally audits its own program in addition to the normal Quality Assurance division audits.

On two occasions, required sampling was not performed due to the controlling procedure failing to identify all Technical Specification required analyses. This was judged to be an isolated instance in an otherwise excellent program. There were five Licensee Event Reports (LER) concerning failure of the Standby Gas Treatment System (SGTS). Two failures were the result of design deficiency, one involved broken equipment, one involved improper post-maintenance testing and one failure involved a trip of one train of the SGTS sample pump while the other train was inoperable. Increased attention should be given to the overall integrity of the SGTS.

An LER was issued to report a January 1983 malfunction of a Chemical Waste Storage Tank level instrumentation which caused an unmonitored release of radioactive water outside the New Radwaste Building. The corrective actions, including periodic testing, seem adequate to prevent recurrence.

An overall improvement in the management of the radwaste area including chemistry was observed. New personnel have been hired to fill vacancies. There is adequate staff with clearly delineated responsibilities. Necessary data was available for evaluation of the program. Corrective actions, where necessary, were timely and acceptable. This was also observed in the transportation area during the November inspection. The licensee is attempting to improve the program and correct deficiencies.

Conclusion

Category 1

Board Recommendations

Following restart from the current refueling outage, return to routine inspection.

4.3 Maintenance (9%)

Inspection of maintenance activities during the outage consists of reviews by the residents primarily of inspection, overhaul and general improvement of the plant. Two specialist inspections reviewed maintenance activities when the refueling outage was just beginning. In addition, this area was reviewed during a team inspection late in the evaluation period.

Maintenance at Oyster Creek is performed by the Maintenance and Construction (M&C) Division which reports to a vice president at the corporate office. All maintenance personnel report to that division. Maintenance is requested by the Plant Division and reviewed for necessity and consistency by the Plant Materiel department. This provides plant operations oriented review, approval, and control of maintenance activities and schedules. The organizational structure with its many interfaces requires close coordination between plant operations, plant engineering and maintenance and construction. While some improvements have been made to improve communications at the organizational interfaces, continual improvement in this area is necessary.

Administrative controls over maintenance were well established and contain provisions for prioritization depending on the activities complexity and urgency. Priorities were initially assigned by the initiator but were reviewed by both Plant Operations and Plant Materiel management. This assures proper prioritization and planning. In addition, the licensee established a procedure for performance and control of urgent work identified during off-normal hours. Daily meetings were conducted during the current refueling outage with both maintenance and representatives from all site organizations to coordinate activities. These meetings appear to be beneficial in keeping management apprised of on-going work. Procurement of safety related equipment was well controlled and documented. One minor violation regarding chemistry resins was identified but is not considered indicative of a program breakdown. Although procurement is acceptable, no current component level quality classification list exists. A licensee group has been formed to resolve this problem. Continued management attention in this area was evident by the numerous levels of review by both plant engineering and quality assurance.

Preventive maintenance (PM) is controlled by a separate group within Plant Materiel Department. Administrative controls are well defined and provide acceptable controls for the conduct of the program. The program is scheduled on both a yearly and weekly basis. NRC review identified that the schedules are comprehensive, reviewed frequently, and accurately reflect the status of the PM program. Checklists were technically accurate and periodically updated to reflect new information. PM tasks were performed by a dedicated group of technicians rotated periodically detailed from the M&C Department. One area associated with preventive maintenance requires some increased attention.

When performing preventive maintenance work when engineering evaluation was required, plant engineering work requests were initiated to obtain that information. NRC observations indicate that once the information was requested, there was little followup by plant materiel to ensure timely response. This needs continued management attention.

There was evidence of routine involvement by QA in maintenance activities through post maintenance quality reviews, quality control hold and witness points of work in progress, quality assurance department observations of various maintenance activities.

The Plant Materiel Department reviews all completed maintenance work packages and has begun a trend analysis program. An initial review was performed by electrical maintenance. Their review was thorough and had substantive recommendations for improvements. NRC review indicates that recommendations had been appropriately acted upon. This was positive evidence of licensee's aggressive approach to solving problems. Further improvements will be made when the review process is expanded to mechanical systems. Increasing senior management involvement in the recommended corrective actions is expected.

Five LER's, associated with electrical breaker maintenance problems, appear to be a relatively high number for this function. This data indicates the need for additional licensee attention in this area. Another LER involved identification of problems with torque switch settings on limitorque valves. This problem, identified by licensee personnel, was based on information received at a maintenance conference. Identification of this problem demonstrates sound technical analysis and aggressive corrective action. Additionally, the licensee has informed other utilities of this potentially generic nature of the problem prior to issuance of NRC documents.

Conclusion

Category 2

Board Recommendations

None.

4.4 Surveillance (15%)

This assessment is based on inspections of the surveillance program by the resident inspectors and by region based inspectors (four inspections of ISI activities).

The licensee controls the routine surveillance test program through issuance of annual master surveillance test schedules. They have administrative controls in place to modify surveillance tests as required by plant conditions and changes to Technical Specifications. Management involvement in review of both test schedules and test results is evident. During this evaluation period, one problem was identified regarding acceptance criteria for a fire pump. Licensee management used this opportunity to review all surveillance tests to ensure technical adequacy and compliance with Technical Specifications. The inspector found surveillance procedures technically adequate, tests conducted on time and results receive proper reviews. The plant engineering staff, responsible for maintaining status of complete surveillances, fell behind in record keeping. This was corrected by reassigning reviews and increasing senior management review. Additionally, the licensee foresees significant improvements when the plan to computerize the surveillance test program is completed.

Successful accomplishment of the leak rate testing program had been a problem in the previous assessment. Inspector review during this period indicates significant improvement. Observations indicate that test procedures have been reviewed and upgraded and the personnel performing tests were knowledgeable of test requirements. Review of the completed test results was performed timely and thoroughly.

Management oversight of the Inservice Inspection and Inservice Test programs appears strong. Administrative controls were found to be well developed including scheduling of activities and assigning proper authority and responsibility for program accomplishments. Appropriate feedback mechanisms were in place to monitor program performance. Appropriate QA interfaces were evident and technician training was good.

During this outage, significant inservice testing and inspection has been conducted as discussed further in Section 4.8.

Conclusion

Category 1

Board Recommendation

None.

4.5 Fire Protection and Housekeeping (2.5%)

The assessment of performance in the fire protection and housekeeping areas are based on inspections by the resident inspectors.

Site fire protection activities are supervised by a full-time assigned individual with responsibility for overall program accomplishment. A dedicated staff is assigned to conduct preventive maintenance and surveillance testing of fire fighting equipment to ensure centralized control of these activities.

The licensee has established a comprehensive fire protection training program. A review of this program identified implementation problems regarding lecture attendance and timely makeup of missed lectures by the fire brigade members. Licensee corrective action for this problem included requiring all brigade personnel to attend scheduled or makeup lectures and to take examinations to ensure that training was adequate.

There has been considerable effort by both NRC and the licensee to attempt to resolve issues involved with fire protection regulations (10 CFR 50, Appendix R). Currently, the licensee has requested 19 technical exemptions and 13 scheduler exemptions to these requirements. These requests are presently under review by NRR.

The licensee has continued to exert significant management attention to housekeeping during this assessment period with the plant in a major refueling and modification outage. Routine tours are made by senior station management to identify and correct housekeeping problems. When conditions became degraded, management has taken aggressive action to improve housekeeping including one occasion when all outage related work was stopped for three days to perform plant cleanup. Although continued emphasis is placed on housekeeping, general worker attitude in this area remains somewhat low.

Radiological housekeeping was viewed to be adequate considering the activity in the plant. Continued attention to contamination control is evidenced by the efforts to decontaminate areas as soon as practicable after completion of activities causing the area contamination. There remains certain contaminated and high radiation areas that require continued attention.

Conclusion

Category 2

Board Recommendations

None.

4.6 Emergency Preparedness (18%)

Analysis in this area is based on observation of the Annual Exercise by the NRC team, three followup inspections by region based inspectors, and observations of plant training exercises by the resident inspectors.

During the annual exercise on May 10, 1983, the licensee demonstrated adequate capability to perform a complicated simulated plant emergency. Although NRC observation of this exercise identified that a substantial improvement was made over the 1982 exercise, a number of deficiencies (most of which were also identified by the licensee) were noted in operational assessment, training, scenario preparation, information flow, dose assessment, and radiation protection evaluation. Continued senior level management attention to emergency planning is evident in that a full time manager is assigned at the site with sufficient staff support. Licensee maintains a three section emergency response rotation and conducts periodic shift and site drills to maintain personnel proficiency between annual exercises. During this evaluation period, specific training was conducted for senior level managers in accident assessment.

The emergency plan and procedures continue to be adequate. Licensee has put forth a large effort to revised emergency procedures to streamline them. One example is a proposed shift of classification of emergency to symptom based approach to conform with emergency operating procedures used by Operations Department personnel.

A number of items remain open (principally associated with Post Accident Sampling Systems) from the emergency appraisal conducted in January, 1982. Licensee progress towards correction of the remaining items is satisfactory. During this assessment, the licensee committed to complete the post-accident sampling system prior to October of 1984. Additionally, a new Technical Support Center is being constructed and will be available about September 1, 1984.

The improved performance noted in 1983 over the 1982 drill was not continued in the licensee's performance of the May 10, 1984 exercise. Although outside this assessment period, deficiencies in communication, EOF environmental data coordination and presentation, and licensee/external agency interfaces were noted.

Conclusion

Category 2

Board Recommendation

None.

4.6 Emergency Preparedness (18%)

Analysis in this area is based on observation of the Annual Exercise by the NRC team, three follow-up inspections by region-based inspectors, and observations of plant training exercised by the resident inspectors.

During the annual exercise on May 24, 1983, the licensee demonstrated adequate capability to perform a complicated simulated plant emergency. Although NRC observation of this exercise identified that a substantial improvement was made over the 1982 exercise, a number of deficiencies (most of which were also identified by the licensee) were noted in operational assessment, training, scenario preparation, information flow, dose assessment, and radiation protection evaluation. Continued senior level management attention to emergency planning is evident in that a fulltime manager is assigned at the site with sufficient staff support. Licensee maintains a three section emergency response rotation and conducts periodic shift and site drills to maintain personnel proficiency between annual exercises. During this evaluation period, specific training was conducted for senior level managers in accident assessment.

The emergency plan and procedures continue to be adequate. Licensee has put forth a large effort to revise emergency procedures to streamline them. One example is a proposed shift of classification of emergency-to-symptom based approach to conform with emergency operating procedures used by Operations Department personnel.

A number of items remain open (principally associated with Post-Accident Sampling Systems) from the emergency appraisal conducted in January 1982. Licensee progress towards correction of the remaining items is satisfactory. During this assessment, the licensee committed to complete the post-accident sampling system prior to October of 1984. Additionally, a new Technical Support Center is being constructed and will be available about September 1, 1984.

The licensee's emergency preparedness staff has expended considerable effort in improving emergency response capabilities. The licensee utilizes team rotation during conduct of drills and exercises to properly train team members. The 1984 exercise, although outside the assessment period, did not reflect the expected improvement over previous exercises as a result of the efforts expended. Some deficiencies in communication, EOF environmental data co-ordination and presentation, and licensee/external agency interfaces were noted.

Conclusion

Category 2

Board Recommendation

None.

4.8 Outage Technical Support (24%)

Assessment in this area is based on region based and resident inspector review of outage work and a team inspection of the licensee's modification process, performed at the end of the assessment period.

During this outage, significant inservice testing and inspection has been conducted. Licensee management attention in this program was evident as demonstrated by corporate requalification of all contract personnel used to perform testing and use of licensee personnel to supervise and perform final reviews of test data. The overall performance of inservice testing was satisfactory.

The licensee performed NDE testing on recirculation system piping for intergranular stress corrosion cracking. During Region I review of this testing, a number of problems with licensee's plotting and evaluation of test data was found. Additionally, the testing was not adequate to determine whether any cracking was present. After conversations and meetings between NRC and Senior Management, the licensee performed additional data evaluation and testing. No crack indications were identified during these activities. Late in the period, similar NDE testing on isolation condenser piping was performed. NRC review of test results identified substantial improvement in data reduction and evaluation.

Major modifications were made during the outage to upgrade plant design and meet new regulatory requirements. Several modifications such as complete replacement of all control room alarm panels were installed to aid operator performance. NRC review of licensee control of the modification process has shown a conservative approach to the resolution of technical issues. Administrative controls associated with modification, construction, testing, and plant staff acceptance are good.

The licensee's system for implementation of planned modifications is adequate. Modifications installation is performed under the control of Maintenance and Construction Division (M&C). Significant portions of the work is then performed by contract organizations. Appropriate QC hold and witness points are inserted in installation procedures and quality assurance observation of activities in progress are routinely observed. Inspector observations did, however, identify problems associated with construction in the areas of procedure change control, welding, and hanger installation associated with Appendix J and Scram Discharge Volume Modifications. Licensee resolution of these concerns is not complete at the end of this assessment period.

Although general control of the modification process has been acceptable, a number of problems associated with design control of modifications has been observed. The licensee's Technical Functions Division has not always advised contractor architect engineers of changes to propose modifications being designed by the contractor. This led to some inadequate review of design changes. In some cases changes were made to contractor

4.7 Security and Safeguards (1.5%)

One regional physical protection inspection and routine resident inspections during the first half of the assessment period identified a total of six physical security violations (including one Severity Level III violation for which a civil penalty was assessed). The violations and other deviations reflected a lack of adequate management attention to implementation of security program requirements and first line supervisory performance. The need for increased management attention to preparation for the major modification and refueling outage work coupled with a marginal audit/surveillance program in the physical security area may have contributed to the program's degradation. An enforcement conference was held in April 1983 to discuss the problem. The licensee's corrective action, which included a reorganization of onsite and corporate security management to effect more direct management involvement in the program and an improved quality assurance auditing program in the security area, was prompt and appears to have been effective. Subsequent routine resident inspections and a regional physical security inspection identified no violations during the second half of the assessment period. However, a deviation from the licensee's commitment to correct one of the previous violations by July 1983 was cited in August 1983. The corrective action was completed later that month.

The training and qualification program resulted in a satisfactory level of job knowledge and adherence to procedures in most cases. It is well defined and carried out by dedicated personnel. The security force staffing level was adequate throughout the period, especially considering the increase in the normal work force as a result of the outage. The position of Site Security Supervisor, which had been filled in about January 1983, was left vacant in July 1983 by the death of the incumbent. The position was again filled in September, 1983 by a very qualified and experienced individual. This is indicative of the licensee's resolve to improve their performance in this area.

Analyses and reporting of events are complete and prompt as are corrective actions. Seven event reports were submitted during the assessment period.

Conclusion

Category 2

Board Recommendations

None.

4.8 Outage Technical Support (24%)

Assessment in this area is based on region based and resident inspector review of outage work and a team inspection of the licensee's modification process, performed at the end of the assessment period.

During this outage, significant inservice testing and inspection has been conducted. Licensee management attention in this program was evident as demonstrated by corporate requalification of all contract personnel used to perform testing and use of licensee personnel to supervise and perform final reviews of test data. The overall performance of inservice testing was satisfactory.

The licensee performed NDE testing on recirculation system piping for intergranular stress corrosion cracking. During Region I review of this testing, a number of problems with licensee's plotting and evaluation of test data was found. Additionally, the testing was not adequate to determine whether any cracking was present. After conversations and meetings between NRC and Senior Management, the licensee performed additional data evaluation and testing. No crack indications were identified during these activities. Late in the period, similar NDE testing on isolation condenser piping was performed. NRC review of test results identified substantial improvement in data reduction and evaluation.

Major modifications were made during the outage to upgrade plant design and meet new regulatory requirements. Several modifications such as complete replacement of all control room alarm panels were installed to aid operator performance. NRC review of licensee control of the modification process has shown a conservative approach to the resolution of technical issues. Administrative controls associated with modification, construction, testing, and plant staff acceptance are good.

The licensee's system for implementation of planned modifications is adequate. Modifications installation is performed under the control of Maintenance and Construction Division (M&C). Significant portions of the work is then performed by contract organizations. Appropriate QC hold and witness points are inserted in installation procedures and quality assurance observation of activities in progress are routinely observed. Inspector observations did, however, identify problems associated with construction in the areas of procedure change control, welding, and hanger installation associated with Appendix J and Scram Discharge Volume Modifications. Licensee resolution of these concerns is not complete at the end of this assessment period.

Although general control of the modification process has been acceptable, a number of problems associated with design control of modifications has been observed. The licensee's Technical Functions Division has not always advised contractor architect engineers of changes to propose modifications being designed by the contractor. This led to some inadequate review of design changes. In some cases changes were made to contractor

4.8 Outage Technical Support (24%)

Assessment in this area is based on region-based and resident inspector review of outage work and a team inspection of the licensee's modification process, performed at the end of the assessment period.

During this outage, significant in-service testing and inspection has been conducted. Licensee management attention in this program was evident, as demonstrated by corporate requalification of all contract personnel used to perform testing and use of licensee personnel to supervise and perform final reviews of test data. The overall performance of in-service testing was satisfactory.

The licensee performed NDE testing on recirculation system piping for intergranular stress corrosion cracking. During Region I review of this testing, a number of problems with licensee's plotting and evaluation of test data was found. Additionally, the testing did not conclusively show that no cracking was present. After conversations and meetings between NRC and senior management, the licensee performed additional data evaluation and testing. No crack indications were identified during these activities. Late in the period, similar NDE testing on isolation condenser piping was performed. NRC review of test results identified substantial improvement in data reduction and evaluation.

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Although general control of the modification process has been acceptable, a number of problems associated with design control of modifications has been observed. The licensee's Technical Functions Division has not always advised contractor architect engineers of changes to proposed modifications being designed by the contractor. This led to some inadequate review of design changes. In some cases, changes were made to contractor design packages without review by the original

design packages without review by the original designer. The licensee initiated a review by corporate QA, at NRC request, to determine if outage modifications meet design criteria. The results of this review will be evaluated by NRC Region I in the near future. Additionally, during installation, several modifications required a significant number of design changes. Examples included Appendix J modifications and the scram discharge volume modifications. In one case, a task force was formed to review and solve associated problems with installation. These problems, in many cases were the result of poor constructability reviews by Technical Functions. Additionally, the licensee did not have a limit on the number of design changes that could be made prior to revising the original design document. Although no installation errors have been identified as a result, the potential for installation errors exists.

Conclusion

Category 2

Board Recommendations

The licensee should be requested to address the interface problems that exist between the licensee and contract engineers performing design work. Inspection of followup corrective actions should be planned.

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Conclusion

Category 2

Board Recommendations

The licensee should be requested to address the interface problems that exist between the licensee and contract engineers performing design work. Inspection of follow-up corrective actions should be planned.

4.9 Licensing

Evaluation in this area is based on review of the licensee's activities in the area of methodology and Cycle 10 reload, Radiological Effluent Technical Specifications (RETS), Core Spray Effectiveness, NUREG-0737 responses, Systematic Evaluation Program (SEP), fire protection review, valve operability, and equipment qualification.

The licensee's performance and management capabilities were generally adequate. The licensee and his contractors have demonstrated good working knowledge of regulatory requirements and excellent levels of technical competence. Management attention and involvement with specific matters of safety is evident, licensee resources are adequate although staffing in various areas should be improved, and satisfactory performance with respect to operational safety is being achieved.

While the licensee provides generally sound and acceptable resolution to the licensing issues, frequent extensions of time are required. Considerable NRC effort and repeated submittals are needed to adequately cover the material to be reviewed. The timeliness of responses was poor with two or three month time delay in responses being the norm. These problems were especially noted in submittals for SEP, RETS, NUREG-0737, TS, and fire protection topics.

Conclusion

Category 2

Board Recommendations

The licensee should be requested to address the adequacy of the corporate engineering support provided to the plant in regards to the content and timeliness of licensing submittals. An adverse trend has been noted, particularly in the areas of SEP and fire protection topics.

5.0 SUPPORTING DATA AND SUMMARIES

5.1 Licensee Event Reports

Tabular Listing	Licensee Event Reports
Type of Events:	
A. Personnel Error	5
B. Design/Man./Const./I. tall.	7
C. External Cause	0
D. Defective Procedure	2
E. Component Failure	6
X. Other	<u>7</u>
TOTAL	27

Licensee Event Reports Reviewed: 83-01 through 83-26 and 84-01, 02 and 05 excluding Security Event Reports.

Causal Analysis:

Four sets of common mode events were identified:

- a. LER's 83-7, 83-15, 83-25, and 83-26 identified events in which incorrect or inadequate procedures contributed to the event.
- b. LER's 83-10, 83-12, and 83-14 involved design deficiencies. Two LER's identified deficiencies with the standby gas treatment system.
- c. LER's 83-4, 83-8, 83-15, 83-20 and 84-2 involved electrical breaker maintenance problems.
- d. LER's 83-6, 83-7, 83-10, 83-11, and 83-14 pertained to the standby gas treatment system. These can be further classified as follows; 2 LER's involved design deficiencies and 2 LER's involved sensing line failures. The relatively large number of problems identified in standby gas treatment may indicate the need for a complete system review.

5.2 Investigation Activities:

None.

5.3 Escalated Enforcement Actions:

- a. Civil Penalties - (83-07) \$40,000: for violations of the physical security plan.
- b. Orders: None.

c. Confirmatory Action Letters: None

5.4 Management Conferences:

Enforcement meeting - 4/18/83: regarding physical security plan violations.

SALP meeting (5/12/83): meeting to discuss Cycle 2 SALP performance.

TABLE 1

TABULAR LISTING OF LERs BY FUNCTIONAL AREA
OYSTER CREEK NUCLEAR GENERATING STATION

<u>AREA</u>	<u>NUMBER/CAUSE CODE</u>				<u>TOTAL</u>
	<u>2A</u>	<u>1B</u>	<u>2E</u>		
Plant Operation and Outage Control					<u>5</u>
Radiological Controls			1D		1
Maintenance	2A	1B		1E 3X	7
Surveillance		3B	1D	2E 4X	10
Fire Protection					
Emergency Preparedness					
Security and Safeguards					
Outage Technical Support	1A	1B			2
Licensing Activities					
Other		1B		1E	<u>2</u>
				Total	27

Cause Codes: A - Personnel Error
 B - Design, Manufacturing, Construction or Installation Error
 C - External Cause
 D - Defective Procedures
 E - Component Failure
 X - Other

TABLE 2LER SUMMARYOYSTER CREEKFEBRUARY 1, 1983 to APRIL 30, 1984

<u>LER NUMBER</u>	<u>SUMMARY DESCRIPTION</u>
83-03/03L	During the performance of maintenance on two "A" control rod drive pump, a vent line was broken. This resulted in the wet-down of a core spray pump and the inadvertent tripping of the "B" control rod drive pump. The "B" pump was immediately restarted.
83-04/03L	Control rod drive pump circuit breaker failure to operate.
83-05/03L	Three high drywell pressure switches tripped at a value greater than specified.
83-06/03L	Low flow switch for standby gas treatment system fan failed, preventing system valves from closing.
83-07/03L	Standby gas system declared inoperable due to plugging of HEPA filter. Identified during surveillance testing.
83-07/03X-1	Subsequent evaluation of LER 83-07/03L revealed an improperly installed pitot tube on flow sensing line.
83-08/03L	Core spray booster pump was found to be inoperable due to installation of an incorrect undervoltage trip coil.
83-09/01T	Main steam isolation valves A and B failed to meet local leak rate test acceptance criteria.
83-10/01T	Discovery of a design deficiency in the standby gas treatment system which prevented inlet and outlet valves from closing when the fan breaker is racked out.
83-11/03L	Standby gas treatment system flow switch failed due to a damaged sensing line.
83-12/01T	Violation of secondary containment due to trunnion room door being open identified during refueling surveillance check-off.
83-13/01T	Violation of secondary containment due to both doors of a reactor building personnel access airlock being open for approximately 30 seconds.

<u>LER NUMBER</u>	<u>SUMMARY DESCRIPTION</u>
83-14/01T	Discovery of a design deficiency in the standby gas treatment system. Heating coils for both trains supplied power from same emergency bus.
83-15/03L	Failure of a reactor building closed cooling water circuit breaker due to improper performance of maintenance which incapacitated an undervoltage trip device.
83-16	Not issued.
83-17/01P	Design deficiency in both diesel generator timing relays.
83-18/03L	Reactor building isolation valve failed to close due to air operator dirt blockage.
83-19/03L	Reactor building isolation valve failed to close due to air operator piston break.
83-20/03L	Failure of service water pump circuit breaker due to a burr on the trip latch.
83-21/03L	Failure of power feed from emergency diesel generator due to ground fault on power feed.
83-22/03L	Two mechanical snubbers found to be inoperable during testing.
83-23	Not issued.
83-24/01T	Limitorque motor operator torque switch settings below original settings.
83-25/03L	Six maintenance and two surveillance procedures did not specify verifying excess flow check valves open.
83-26/01T	Fuel pool cooling heat exchangers no longer meet seismic requirements due to addition of lead for shielding.
84-001	Diesel fuel oil level less than technical specification required level.
84-002	Failure of circuit breaker undervoltage trip devices.
84-005	A through-wall crack was discovered on the isolation condenser piping during a system hydrostatic test.

TABLE 3

VIOLATIONS (2/1/83-4/30/84)OYSTER CREEK NUCLEAR GENERATING STATIONA. Number and Severity Level of Violations1. Severity Level

Severity Level I	0
Severity Level II	0
Severity Level III	1
Severity Level IV	13
Severity Level V	<u>5</u>

TOTAL 19

B. Violations vs. Functional Area

<u>FUNCTIONAL AREAS</u>	<u>Severity Levels</u>				
	<u>I</u>	<u>II</u>	<u>III</u>	<u>IV</u>	<u>V</u>
Plant Operations					
Radiological Controls					2
Maintenance				1	
Surveillance				1	1
Fire Protection				1	
Emergency Preparedness					
Security and Safeguards			1	6	1
Refueling Outage				4	1
Licensing Activities					
TOTALS			1	13	5

TOTAL VIOLATIONS: 19

TABLE 4INSPECTION HOURS SUMMARY (2/1/83-4/30/84)OYSTER CREEK NUCLEAR GENERATING STATION

	<u>HOURS</u>	<u>% OF TIME</u>
Plant Operations	757	21
Radiological Controls	325	9
Maintenance	307	9
Surveillance	535	15
Fire Protection/Housekeeping	90	2.5
Emergency Preparedness	640	18
Security and Safeguards	59	1.5
Refueling	933	24
Licensing	<u>No data available</u>	
TOTAL	3646	

TABLE 5

INSPECTION REPORT ACTIVITIESOYSTER CREEK NUCLEAR GENERATING STATION

<u>REPORT NO. AND INSPECTION DATES</u>	<u>INSPECTOR</u>	<u>AREA INSPECTED</u>
83-03 2/7/83-2/18/83	Specialist	Emergency Preparedness Items
83-04 2/1/83-3/7/83	Residents	Routine Resident Inspection
83-05 2/14-18, 3/1-4, 3/24, 3/28, 1983	Specialist	ISI Activities
83-06 2/22/83-2/25/83	Specialist	Maintenance, surveillance calibration activities.
83-07 3/14/83-3/17/83	Specialist	Security Plan and Implementing Procedures
83-08 3/8/83-4/4/83	Residents	Routine Resident Inspection
83-09 3/16/83-3/18/83	Specialist	Public Prompt Notification System
83-10 4/6/83-4/8/83	Specialist	Implementation of radiation protection program
83-11 4/5/83-5/2/83	Resident	Routine Resident Inspection
83-12 4/18/83	Specialist	Enforcement Conference Physical Security Program
83-13 5/11/83-5/12/83	Specialist	Design review of plant shielding
83-14 5/3/83-6/8/83	Residents	Routine Resident Inspection

<u>REPORT NO. AND INSPECTION DATES</u>	<u>INSPECTOR</u>	<u>AREAS INSPECTED</u>
83-15 5/23/83-5/25/83	NRC Team and Residents	Emergency Preparedness Inspection
83-16 8/23/83-8/26/83	Specialist	Security System Power Supply/Training/Security
83-17 6/9/83-7/13/83	Residents	Routine Resident Inspection
83-18 7/11/83-7/15/83	Specialist	Effluent control and Radioactive Waste program
83-19 7/12/83-7/15/83	Specialist	Stress corrosion cracking and welding activities
83-20 7/14/83-8/17/83	Residents	Routine Resident Inspection
83-21 7/19,25,26/83	Specialist	Ultrasonic data during weld examinations
83-22 8/18/83-9/21/83	Residents	Routine Resident Inspection
83-23 9/22/83-11/7/83	Resident	Routine Resident Inspection
83-24 10/12,17-21,27/83	Specialist	Review of QA Program, QC Surv, drawings, procedures, instructions and work observ.
83-25 10/17/83-10/21/83	Specialist	Licensee's radiation protection and effluent control program
83-26 11/7/83-12/31/81	Resident	Routine Resident Inspection
83-27 11/29/83-12/2/83	Specialist	Trans. activities - radioactive waste mgmt programs
83-28 12/12-15/83	Specialist	Radioactive waste program

<u>REPORT NO. AND INSPECTION DATES</u>	<u>INSPECTOR</u>	<u>AREAS INSPECTED</u>
84-01 1/1-1/13/84	Resident	Routine
84-02 1/16-20/84	Specialist	Licensee's radiation protection program.
84-03 2/1-3/15/84	Resident	Routine
84-04 2/7-10/84	Specialist	Licensee's inservice inspection program.
84-05 2/21-24/83	Specialist	Emergency preparedness items
84-06 3/12-16/84	Resident/ Specialist (RHR/BETA Team Inspec)	Licensee's organization and program implemen- tation in maintenance, training and procedu- ral controls.
84-07 3/9-10/84	Specialist/ Resident	Inspection of activities associated with torus shell thickness
84-08 3/7/84	Specialist	Radiological control incident review.
84-09 3/26-30/84; 4/2-3/84	Residents/ Specialist	Readiness Assessment Team Inspection of modi- fications, evaluating the design, construc- tion/installation, inspection, testing and acceptance for operation modifications.
84-10 3/16-4/30/84	Resident/ Specialist	Routine resident inspection and specialist review of isolation condenser cracks.

TABLE 6

ENFORCEMENT DATAOYSTER CREEK NUCLEAR GENERATING STATION

<u>INSPECTION NUMBER</u>	<u>SUBJECT</u>	<u>REQ.</u>	<u>SEV.</u>	<u>AREA</u>
83-04	Failure to X-ray or physically search hand carrier package brought through a protected area portal.	Provisional operating license DPR-16	IV	7
83-04	Failure to ensure continuous surveillance of an escorted person.	Tech Spec 6.8.1	IV	7
83-04	Failure to ensure material important to safety and traceable quality assurance documentation.	10CFR50	IV	3
83-07	Failure to notify the commission of a change to the security plan; failure to maintain an effective protected area barrier; failure to record intrusion alarms.	Accepted Security Plan	III	7
83-07	Failure to observe an isolation zone with CCTV	Accepted Security Plan	IV	7
83-07	Failure to guard and control access to vital areas.	Accepted Security Plan	IV	7
83-07	Failure to maintain a protected area barrier height.	Accepted Security Plan.	V	7
83-08	Violation of physical security plan.	Provisional operating license DPR-16.	IV	7
83-20	Failure of an individual to properly use protective clothing.	Tech. Spec 6.8.1	V	2

<u>INSPECTION NUMBER</u>	<u>SUBJECT</u>	<u>REQ.</u>	<u>SEV.</u>	<u>AREA</u>
83-20	Violation of physical security plan	Provisional operating license DPR-16	IV	7
83-23	Failure to provide hourly fire watch while the fire door between the diesel generator bays were fouled.	Tech Spec	IV	5
83-24	Failure to translate design basis items into specifications, drawings, procedures and instructions.	10CFR50	V	8
83-25	Failure to analyze a monthly liquid effluent discharge batch for tritium.	Tech Spec 4.6.B.2.C	V	4
83-26	Failure of a surveillance procedure to identify the development of an inadequate pump head pressure.	Tech Spec 6.8.1	IV	4
83-27	Failure to verify drain line and access plugs were properly sealed prior to transport.	10CFR71.12	V	2
84-09	Failure to review design change commensurate with original design; failure to incorporate design changes and regulatory requirements into specification, drawings, procedures and instructions.	10CFR50 APP B	IV	8
84-09	Failure to prescribe and accomplish quality installations.	10CFR50 APP B	IV	8
84-09	Failure to adequately control design information.	10CFR50 APP B	IV	8
84-09	Failure of QC inspections to verify conformance of construction activities.	10CFR50 APP B	IV	8

DEVIATION

83-16	Failure to meet a commitment to the commission concerning physical security.			
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ENCLOSURE 3
UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
631 PARK AVENUE
KING OF PRUSSIA, PENNSYLVANIA 19406



No. 50-219

JUL 10 1984

GPU Nuclear Corporation
ATTN: Mr. P. B. Fielder
Vice President and Director
Oyster Creek Nuclear Generating Station
P. O. Box 388
Forked River, New Jersey 08731

Gentlemen:

Subject: Systematic Assessment of Licensee Performance (SALP); Report No. 50-219/84-19

The NRC Region I SALP Board has reviewed and evaluated the performance activities of the Oyster Creek Nuclear Generating Station for the period February 1, 1983 to April 31, 1984. The results are contained in the enclosed report dated June 21, 1984. A meeting to discuss this assessment has been tentatively scheduled for July 16, 1984. The meeting will be held in Forked River, New Jersey near the plant.

The SALP Board concluded that satisfactory or higher levels of performance occurred in all functional areas. It was noted that steady or improved performance had occurred in functional areas with the exception of Security, Outage Technical Support (special assessment area), and Licensing. In the Security area performance had substantially degraded during the first half of the assessment period. However, improvement was noted in the second half after staffing changes were implemented.

With regard to the Outage Technical Support and Licensing assessments, although satisfactory performance was assessed, we are concerned with corporate engineering support provided to the plant in that a number of problems associated with design control, engineering support, and timeliness of responses were noted. Similar problems were noted in the earlier assessment for Three Island Unit No. 1. If uncorrected, these problems could potentially lead to a further degradation in your overall performance. You should be prepared to discuss your efforts to improve the corporate engineering support functions at the meeting.

We had noted improved performance in your 1983 emergency drill over the previous year's drill. However, we do not believe this improving trend was continued into the May 10, 1984 drill. Although this latest drill is outside the assessment period, we would like you to be prepared to discuss any improvements you plan for future drills.

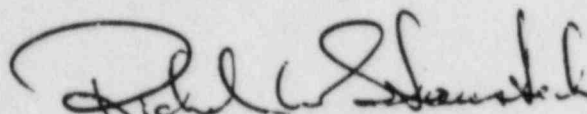
The meeting is intended to be a dialogue wherein any comments you may have regarding our report may be discussed. Written responses addressing the above areas are requested within 30 days of the meeting.

8409200058

JUL 10 1984

Your cooperation is appreciated.

Sincerely,



Richard W. Starostecki, SALP
Board Chairman
Division of Project and
Resident Programs

Enclosure: As Stated

cc w/encls:

BWR Licensing Manager
Licensing Manager, Oyster Creek
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
SALP Board Members
NRC Resident Inspector, TMI-1