Public Service
Electric and Gas
Company

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AUG 0 4 1995

LR-N95125

Mr. T. T. Martin, Administrator - Region I
U. S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Martin:

SHUTDOWN COOLING BYPASS EVENT
DOCUMENTATION OF JULY 31, 1995 MEETING
HOPE CREEK GENERATING STATION
FACILITY OPERATING LICENSE NPF-57
DOCKET NOS. 50-354

I appreciate the cpportunity made available to my staff on July 31, 1995 to provide information to you and your staff on the Hope Creek shutdown cooling bypass event. We clearly understand the seriousness of the event and will ensure that our root cause is comprehensive and that additional corrective actions are completed in a timely manner. The corrective actions identified to date and commitments to you were discussed at the July 31 meeting. The attachment to this letter summarizes the commitments made by my staff in the July 31 meeting.

Should you have questions concerning this transmittal please contact me promptly.

Sincerely,

Attachment

A005

C Mr. D. Jaffe, Licensing Project Manager - Hope Creek
U. S. Nuclear Regulatory Commission
One White Flint North
11555 Rockville Pike
Rockville, MD 20852

Mr. R. Summers (S05)
USNRC Senior Resident Inspector - Hope Creek

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ATTACHMENT 1

SHUTDOWN COOLING BYPASS EVENT
DOCUMENTATION OF JULY 31, 1995 MEETING
HOPE CREEK GENERATING STATION
FACILITY OPERATING LICENSE NPF-57
DOCKET NOS. 50-354 **LR-N95125**

The commitments and actions from the July 31, 1995 meeting with your staff on the Hope Creek shutdown cooling bypass event are listed below.

1. We will determine the minimum flow required to prevent stratification and to ensure adequate temperature indication and incorporate this limit into the procedure.

2. We will complete the heat balance calculations and provide them to the NRC. If appropriate, we will account for the heat transfer paths noted by Mr. W. Lyon (NRC).

3. We will modify our operator training programs to capture the lessons learned from the event. Cycle 1 of licensed operator requalification will include a comprehensive review of this event including root causes and corrective actions. Additionally, this event will be included in initial licensed operator training

4. We will investigate the history of cracking valves open to prevent thermal binding to determine if this was done previously.

5. We will determine when stroking the valves was proceduralized.

6. We will verify if the valve vendor was contacted on the issue of thermal binding for the subject valves.

7. We intend to review the need for preventing thermal binding of the recirculation pump isolation valves while cooling down on RHR shutdown cooling and determine a final resolution of this issue for these valves. In the interim, our procedures will be changed to minimize the potential of RHR bypassing the core. Specifically, the system operating procedure has been revised and the integrated and abnormal operating procedures will be revised based on engineering input regarding manipulation of these valves.

8. We will provide copies of the applicable operating procedures to the NRC.

9. We will finalize our position on whether stroking the valves to prevent thermal binding is considered a work around.

10. We will communicate with General Electric and other utilities to determine the generic issues which should be communicated to the industry.

11. We will resolve operating experience feedback issues (e.g., review our response to the Oyster Creek stratification event, etc.).

12. We will determine the accuracy of recirculation flow instrumentation relative to flow direction.

13. We will reassess the basis for maintaining level less than that required for natural circulation while shutdown cooling is in operation.

14. The Operating Engineer - Shift will conduct a focused control room observation beginning August 7 to evaluate procedural compliance of shift personnel, whether control room personnel are properly focused on their roles, and administrative duties which should be re-assigned or eliminated. This will allow verification of the effectiveness of our corrective actions.

15. We will ensure operator knowledge and training is considered as part of the root cause.

16. We will submit a detailed LER discussing this event, our analysis, and corrective actions.

17. We will investigate issues relative to communications with NRC on the event.

18. The independent review team will complete their evaluation by August 4, 1995.

19. The common cause analysis root cause team reviewing the increase in operator errors will complete their evaluation by August 30, 1995.

20. Additional corrective actions will be taken based upon the findings of the independent team and root cause team commissioned to address the increased operator error rate.

With the exception of Action 20, these actions will be completed by August 30, 1995. As additional corrective actions are identified in accordance with Action 20, appropriate completion dates will be asigned.