

DCS

Public Service
Electric and Gas
Company

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609-339-5700

JAN 11 1996
LR-N95258

Mr. James Lieberman
Director, Office of Enforcement
United States Nuclear Regulatory Commission
One White Flint North
11555 Rockville Pike
Rockville, MD 20852-2738

Dear Mr. Lieberman:

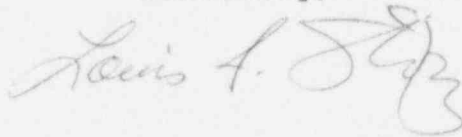
**REPLY TO A NOTICE OF VIOLATION
LETTER WITH PAYMENT OF CIVIL PENALTY
SHUTDOWN COOLING BYPASS EVENT
INSPECTION REPORT NO. 50-354/95-81
HOPE CREEK GENERATING STATION
FACILITY OPERATING LICENSE NPF-57
DOCKET NO. 50-354**

Pursuant to the provisions of 10CFR2.201, this letter submits the response of Public Service Electric and Gas Company to the notice of violation issued to the Hope Creek Generating Station in a letter dated December 12, 1995.

PSE&G does not dispute the violation nor request mitigation of the proposed civil penalty. An electronic transfer of funds payable to the Treasurer of the United States in the amount of the proposed civil penalty has been made.

Should you have any questions or comments on this transmittal, do not hesitate to contact us.

Sincerely,



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ATTACHMENT

REPLY TO NOTICE OF VIOLATION
SHUTDOWN COOLING BYPASS EVENT
INSPECTION REPORT NO. 50-354/95-81
HOPE CREEK GENERATING STATION
DOCKET NO. 50-354

LP-N95258

I. INTRODUCTION

On July 8-9, 1995, the Hope Creek Generating Station experienced an event involving the partial bypass of shutdown cooling flow from the reactor vessel. On August 7-16, 1995, the NRC conducted a Special Team Inspection of this event. The results of that inspection were described in NRC Inspection Report No. 354/95-81, dated September 25, 1995 and in an NRC letter dated October 11, 1995. On November 6, 1995, an enforcement conference was held to discuss this event and associated apparent violations. Subsequently, the NRC issued a notice of violation for four violations of NRC requirements in a letter dated December 12, 1995.

The notice of violation describes the following four violations of NRC requirements: (1) failure to follow operating procedures for reactor recirculation system operation; (2) failure to comply with Technical Specification 3.4.9.2, "Reactor Coolant System - Cold Shutdown"; (3) failure to comply with Technical Specification 3.3.2, "Isolation Actuation Instrumentation"; and (4) failure to comply with Technical Specification 3.6.1.4, "Containment Systems, Main Steam Isolation Valve (MSIV) Sealing System." These violations have been categorized in the aggregate as a Severity Level III problem (Supplement I).

In accordance with the provisions of 10CFR2.201, Public Service Electric and Gas Company hereby submits a written response to the notice of violation which includes for each violation: (1) the reason for the violation; (2) the corrective steps that have been taken and the results achieved; (3) the corrective steps that will be taken to avoid further violations; and (4) the date when full compliance will be achieved.

II. REPLY TO THE NOTICE OF VIOLATION

In this response, the failure to follow operating procedures for reactor recirculation system will be referred to as Violation A, the failure to comply with Technical Specification 3.4.9.2, "Reactor Coolant System - Cold Shutdown," will be referred to as

Violation B, the failure to comply with Technical Specification 3.3.2, "Isolation Actuation Instrumentation," will be referred to as Violation C and the failure to comply with Technical Specification 3.6.1.4, "Containment Systems, Main Steam Isolation Valve (MSIV) Sealing System," will be referred to as Violation D.

A. Violation A

1. Description of the Notice of Violation:

"Technical Specification 6.8, 'Procedures and Programs,' subsection 6.8.1.a, requires, in part, that 'Written procedures shall be established, implemented, and maintained covering the activities referenced, including the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Rev. 2, February 1978.'

Section 4 of Appendix A of Regulatory Guide 1.33, Revision 2, February 1978, requires procedures for Startup, Operations, and Shutdown of Safety-Related BWR Systems, including instructions for energizing, filling venting, draining, startup, shutdown, and changing modes of operation, for the shutdown cooling and Reactor Vessel Head Spray System.

Licensee procedure HC.OP-SO.BB-0002(Q) - Rev. 22, 'Reactor Recirculation System Operation', Limitation 3.2.17, written to satisfy the requirements in Appendix A of Regulatory Guide 1.33, requires that 'To preclude thermal binding, the suction and discharge valves shall alternately be opened and closed for each 75 degree F temperature drop in the isolated loop.'

Contrary to the above, on July 8-9, 1995, licensed Reactor Operators failed to implement Limitation 3.2.17, of procedure HC.OP-SO.BB-0002(Q) - Rev. 22, "Reactor Recirculation System Operation" in that the recirculation pump discharge valves (F031A&B) were opened and left open (between 6:45 p.m. and 9:00 p.m. on July 8, 1995, for F031A, and between 11:00 a.m. on July 8, 1995, and 5:50 a.m. on July 9, 1995, F031B) to preclude thermal binding, rather than opened and closed for each 75 degree F temperature drop in the isolated loop. This resulted in the bypass of shutdown cooling flow from the reactor vessel, a loss of the temperature monitoring capability provided by the shutdown cooling system, and the

inadvertent and undetected change of plant operational condition from cold shutdown to hot shutdown on two separate occasions."

2. Response to Notice of Violation

PSE&G does not dispute the violation.

i. Description of Event

As described in LER 95-016-01, on July 8, 1995, the Hope Creek Generating Station was removed from service (Ref. LER 95-015-00) in compliance with Technical Specifications for the inoperability of the AK400 Chiller associated with the Control Room Emergency Filtration System. With the plant in Operational Condition 4, and with Residual Heat Removal (RHR) loop "B" in service, the operators periodically cycled (open and closed) Recirculation Pump discharge valves 1BBHV-F031A and 1BBHV-F031B to prevent thermal binding in accordance with Station Operating Procedure HC.OP-SO.BB-0002 (Q), "Reactor Recirculation System Operation".

At 0940 hours and again at 0950 hours, on July 8, 1995, the shift attempted to stroke valve 1BBHV-F031A to avoid potential thermal binding, but the valve would not open due to thermal binding. The cooldown proceeded, and at 1057 hours Operational Condition 4 was entered.

At 1100 hours, valve 1BBHV-F031B, which had been successfully cycled twice previously, was cracked open and left open to ensure that it did not bind, as occurred with 1BBHV-F031A. This was not in accordance with Station Operating Procedures which require opening and closing the valve. At 1152 hours, and in accordance with station procedures, the operators opened the reactor head vent valves.

At 1635 hours, the "B" RHR shutdown cooling loop was removed from service to support testing per station operating procedures. At this time, with valve 1BBHV-F031B cracked open, 2000 GPM of shutdown cooling flow was bypassing the reactor core. This occurred for approximately six hours and allowed temperatures higher than those indicated at the RHR

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heat exchanger inlet to develop within the vessel. When the RHR shutdown cooling loop was removed from service, the temperatures rose to the boiling point and pressure began to increase within the vessel. Pressures were greater than atmospheric for approximately 30 minutes and peaked at approximately 17 psig ($T_{sat} = 254$ F). The loop was returned to service at 1709 hours, and the operators observed that the "B" RHR heat exchanger inlet temperature had increased from 163 degrees F to 182 degrees F. However, the indications were lower than the actual temperatures in the vessel due to the RHR shutdown cooling flow bypassing the vessel, which continued to affect the indicated RHR heat exchanger inlet temperatures. The pressures returned to atmospheric and the RHR heat exchanger inlet temperature returned to 163 degrees F after the "B" RHR shutdown cooling loop was restored to service.

When the drywell was determined safe for personnel access, two equipment operators entered to tag out the inboard Main Steam Isolation Valves, inspect the 1AVH212 drywell cooler for leakage, and to manually unseat valve 1BBHV-F031A. When operators attempted to unseat the 1BBHV-F031A valve (approximately 1845 hours) the valve was found to open freely. The valve was moved electrically from the control room and positioned off the seat (again not in accordance with procedure), indicating dual position. Upon exiting the drywell (shift turnover time) the operators reported noticing a large amount of condensation (fogging of safety glasses, visible water droplets on equipment and surfaces, etc.).

At shift turnover, the reactor coolant temperature was indicating 163 degrees F, on the RHR Heat Exchanger inlet temperature element as well as the reactor water cleanup bottom head drain temperature indicator. The problems and status associated with the 1BBHV-F031 valves were discussed by the Reactor Operators (RO) during turnover. The Senior Nuclear Shift Supervisor (SNSS) turnover took until 2000 hours due to other shift related activities. The lengthy turnover caused the SNSS to miss the shift turnover briefing. After completing his turnover, the SNSS reviewed the status of the control panels with the NSS at approximately 2030 hours. During the review, the SNSS

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noticed that the 1BBHV-F031B had dual indication. The SNSS had been told of the problem with 1BBHV-F031A but only now discovered that 1BBHV-F031B was also cracked open. A 2000 GPM "B" recirculation loop flow was also observed by the SNSS. Shift management made a decision to close both recirculating pump discharge valves (1BBHV-F031A/B) at this time.

At 2045 hours, a tagout of the Primary Containment Instrument Gas system was implemented. This removed the air supply to all drywell pneumatic loads and caused the chilled water supply valves for the drywell coolers to fail open. This provided a flow path from a known leak in the 1AVH212 Drywell Unit Cooler to the drywell floor drain sump.

At 2100 hours, the operators remotely closed 1BBHV-F031A, but were unable to close 1BBHV-F031B. The operators opened 1BBHV-F031B further in order to establish the close permissive, which was believed to not have been established at the time (subsequent investigation revealed the cause of this failure to be attributed to a torque switch failure). A third unsuccessful attempt was made to close the valve. At this time the operators did not note that the "B" recirculation loop flow had increased to 4000 GPM from 2000 GPM due to further opening of the valve.

Shortly thereafter, a slow increase in Drywell Leak Detection (DLD) flow was noticed. Previously, DLD had been a steady 0.4 GPM. The increase was attributed to the previously known leak from a cooling coil in the 1AVH212 drywell unit cooler discussed above. Later, condensate from the head vent steam was determined to have caused the slow increase in DLD flow.

At 0100 on July 9, 1995, a high reading on a reactor pressure trip unit (60 psig) prompted the operators to investigate the available margin to the shutdown cooling isolation trip (82 psig). Operators were concerned about an inadvertent actuation of isolation instrumentation and potential loss of shutdown cooling. Following investigations by I&C technicians, voltage readings determined that pressures on all four channels were between nineteen (19) and twenty four (24) psig. The readings were

attributed to either elevation head, or "zero" on the 1500 psig scale.

At 0130 hours, a tentative decision was made to enter the drywell to close the 1BBHV-F031B valve. At 0230 the SNSS cancelled that decision due to safety concerns relative to drywell conditions previously detected by the operators during their earlier drywell entry. He also wanted to wait until RHR was again secured so that 1BBHV-F031B could be stroked open fully and then closed. The belief was that the differential pressure (DP) across the valve was causing its failure to move.

At 0454 hours, the "B" RHR loop was secured to perform a surveillance. During this time, the operators attempted to fully open 1BBHV-F031B (expecting to be able to close the valve with no DP across the valve due to RHR pump shutdown). The valve fully opened but would not close.

At 0500 hours the operators dispatched an electrician to the breaker, and an equipment operator to the drywell, during which time the SNSS and NSS discussed the possibility of closing the "B" recirculation pump suction valve (1BBHV-F023B) as a contingency plan. They determined that no procedural guidance was available for this and additionally expected 1BBHV-F031B to be closed very soon.

At 0508 hours the "B" RHR pump was restarted. Post event review of the "B" recirculation loop flow recorder strip chart indicated that loop flow had only slightly increased. This indicated that the cracked open 1BBHV-F031B valve was previously passing maximum flow (i.e., 4000 GPM). At 0550 hours, 1BBHV-F031B was locally manually closed and the RHR heat exchanger inlet temperature increased to 191 degrees F before returning to the previous value of 155 degrees F. This indicated that insufficient RHR flow had been circulated through the reactor core.

Description of Operational Condition Changes

During the first inadvertent Operational Condition change from Cold Shutdown to Hot Shutdown (1635 hours to 1709 hours on 7/8/95), the LCO for TS 3.6.3, "Primary Containment

Isolation Valves," and the LCO for TS 3.3.2, "Isolation Actuation Instrumentation," were not met because of tagging to support the outage. As a result of not meeting the requirements of these LCOs, the requirements of TS LCO 3.0.4 were not met. TS 3.0.4 prohibits entry into an Operational Condition when the conditions for the LCO are not met and the associated ACTION requires a shutdown.

During the second inadvertent Operational Condition change from Cold Shutdown to Hot Shutdown (from 2100 hours on 7/8/95 to 0550 hours on 7/9/95), the following LCOs were not met: TS 3.3.2, "Isolation Actuation Instrumentation,"; TS 3.6.1.4, "MSIV Sealing System,"; TS 3.6.3, "Primary Containment Isolation Valves,"; and TS 3.7.1.2, "Station Service Water System." This was caused by clearances that existed to support the outage. As a result of not meeting the requirements of the LCO for TS 3.3.2, 3.6.1.4 and 3.7.1.2 during this second inadvertent mode change, the requirements of TS LCO 3.0.4 were again not met.

ii. Reason for Violation

On three occasions operators manipulated valve 1BBHV-F031B and left it open without procedural guidance and without determining the impact of leaving the valve open. Ineffective oversight by Operations Department management is the root cause that allowed the other contributing causes to exist.

Thermal binding of the 1BBHV-F031 valves and torque switch failure on 1BBHV-F031B were the initiating condition and the initiating equipment failure, respectively. The effects of these conditions were worsened by subsequent actions.

Procedural Non-compliance

Plant operating procedures HC.OP-SO.BB-0002(Q), "Reactor Recirculation System Operation" and HC.OP-SO.BC-0001(Q), "Residual Heat Removal System Operation" provide guidance on operating their respective systems. Neither procedure allows the 1BBHV-F031A or the 1BBHV-F031B valve to remain in a mid-position indefinitely while the RHR system is in service. Thermal binding was assumed to have occurred on

1BBHV-F031A. Operators non-conservatively rationalized that the guidance to stroke the valve allowed them to leave 1BBHV-F031B cracked open in order to meet the intent of a requirement in the recirculating water pump procedure which was put in place to prevent thermal binding.

Contributing Causal Factors - Inadequate Knowledge, Skills, and Training/Ineffective Operating Experience Review

Operators have not been adequately trained on similar industry events relative to the effect of having RHR flow bypass the core and return to the RHR pump suction via the recirculating water pump loop. Events described in industry operating experience at Quad Cities and Oyster Creek were not utilized for training at Hope Creek since it was believed that design and/or procedural differences would preclude a similar event at Hope Creek.

A deficiency exists in the operators knowledge of the operation of the torque and limit switches on a Limitorque motor operated valve. The lack of full understanding (jogging valves open to make up the close permissive) prompted the operator to open the 1BBHV-F031B further in an unsuccessful attempt to enable valve operation in the close direction. This action increased the amount of flow through the "B" recirculation loop to a point where more decay heat was being produced than was being removed.

Contributing Causal Factor - Less than Adequate Work Practices (Poor On-shift Communications)

When the 1BBHV-F031B valve was initially cracked open at 1100 on July 8, 1995, the Nuclear Controls Operator (NCO) failed to communicate the action to shift management. This denied shift management the opportunity to recognize the procedure non-compliance and to correct the situation.

Contributing Causal Factor - Inadequate Procedures

The precaution and limitation in the recirculation procedure, "to preclude thermal binding, the suction and discharge valves shall be alternately opened and closed,"

lacked sufficient clarity to ensure that it was consistently applied by all operators.

iii. Corrective Steps That Have Been Taken and Results Achieved

The corrective actions for this event are described below. Many of these corrective actions have been identified in documents previously provided to the NRC or in previous communications with the NRC. Each corrective action has been grouped according to the associated root cause, contributing cause, or area of applicability.

Procedure Non-Compliance

A primary causal factor for this event was procedure non-compliance. On July 10, Night Order Book (NOB) entries were made requiring the SNSSs to review this event with their shifts as soon as possible and to re-state department expectations with regard to procedure usage. Operations Management personnel have stressed their expectation of verbatim procedure compliance to shift personnel. In addition, the Operations Department has established a performance indicator and will be implementing it to periodically assess the fulfillment of their expectations relating to procedure compliance by February 15, 1996.

Inadequate Operator Knowledge, Skills, and Training

This event, its root causes and corrective actions were reinforced with all shift operations personnel during Segment 1 of 1995/96 Licensed Operator Requalification Training as well as with SRO Initial/Upgrade class in training at the time following the event. In addition, Limitorque training has been provided to Hope Creek Operations personnel. Cycle 1 of licensed operator training included a comprehensive review of this event including root causes and corrective actions.

On July 15th, stand down meetings were conducted by the SNSSs with each shift to review effective tools for preventing operator errors and to review use of these tools in the context of those operating events that occurred during the forced outage of July 1995.

Inadequate Procedures

Operating procedures have been revised to reflect lessons learned, including: 1) the minimum shutdown cooling flow required to assure adequate cooling; 2) strategies for level control while in shutdown cooling; 3) indications to be used if conflicting information develops regarding shutdown cooling parameters; and 4) the recommendations from Engineering, which include eliminating stroking of the recirculation system suction and discharge valves and guidance associated with thermal binding of 1BBHV-F031A/B.

In addition, the basis for maintaining level less than that required for natural circulation while shutdown cooling is in operation has been reassessed. A revision to procedure HC.OP-IO.ZZ-0004(Q) was completed on August 25, 1995, to require raising coolant level to above 80 inches once Operational Condition 4 is entered.

The solution to the issue of thermal binding of the recirculation suction and discharge valves has been re-evaluated. General Electric has provided specific recommendations regarding this issue and advised against cycling the valves during shutdown cooling. Procedures have been revised accordingly.

Less Than Adequate Work Practices (Poor On-Shift Communications and Ineffective Oversight by Operations Department Management)

Due to identified performance deficiencies in the Operations Department, one SNSS, three additional SROs and two ROs were removed from shift and replaced with more capable performers. Additional changes will be made as appropriate, which may include hiring SROs and ROs from outside the company.

To further improve Operations Department performance, the Operations Manager was removed from the position. An interim manager is filling the position while a permanent manager is being sought.

Hope Creek has provided training, including a videotape on effective communications, to station personnel.

Ineffective Operating Experience Feedback (OEF) Program

It has been determined that ineffective OEF review contributed to this event. Nuclear Reliability and Assessment (NRA) has compiled industry shutdown cooling events for analysis. OEF recommendations for application at Hope Creek have been presented to the Operations Department. The evaluation of these recommendations will be completed by 1/31/96.

An evaluation of the NBU OEF program has been completed. The recommendations identified by the evaluation are being reviewed and will be implemented, as appropriate. Additional details concerning this corrective action were previously transmitted in the response to a Notice of Violation 354/95-11 (PSE&G letter LR-N95175, dated October 19, 1995).

iv. Corrective Steps that Will Be Taken to Avoid Further Violations

No additional corrective actions are planned.

v. Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

B. Violation B

1. Description of the Notice of Violation

"Technical Specification Limiting Condition of Operation (LCO) 3.4.9.2 "Reactor Coolant System - Cold Shutdown" requires that two shutdown cooling mode loops of the Residual Heat Removal (RHR) system shall be operable and, unless at least one recirculation pump is in operation, at least one shutdown cooling mode loop shall be in operation. A footnote to this Technical Specification allows that a shutdown cooling pump may be removed from operation for up to 2 hours per 8 hour period provided that the other loop is operable. The LCO 3.4.9.2 Action Statement requires the following: (1) that with less than the above required RHR shutdown cooling mode loops operable, within one hour and at least once per 24

hours thereafter, demonstrate the operability of at least one alternate method of decay heat removal for each inoperable RHR shutdown cooling mode loop; and (2) with no RHR shutdown cooling mode loop or recirculation pump in operation, within one hour establish reactor coolant circulation by an alternate method and monitor reactor coolant temperature and pressure at least once per hour.

Contrary to the above, on July 8-9, 1995, two shutdown cooling mode loops of the residual heat removal system were not operable. Specifically, the "B" RHR shutdown cooling loop was inoperable from 11:00 a.m. on July 8, 1995 until 5:50 a.m. on July 9, 1995, in that it was unable to perform its intended safety function of maintaining the reactor in cold shutdown (CSD) because cooling flow bypassed the reactor core. The "A" RHR shutdown cooling loop, while not in operation, was also inoperable from 6:45 p.m. until 9:00 p.m. on July 8, 1995, in that its recirculation pump discharge valve (F031A) was open. However, the Licensee did not (1) demonstrate the operability of at least one alternate method capable of decay heat removal for each inoperable RHR shutdown cooling mode loop within one hour; nor (2) establish reactor coolant circulation by an alternate method within one hour when no RHR shutdown cooling mode loops were operable."

2. Response to Notice of Violation

PSE&G does not dispute the violation.

i. Description of Event

The description of the event is provided in the response to Violation A above.

ii. Reason for Violation

The principal cause for the Technical Specification violation was the procedural non-compliance described in Violation A above. The causes of the procedural non-compliance are addressed in Violation A.

iii. Corrective Steps that Have Been Taken and Results Achieved

Corrective actions for this violation are described in Violation A above.

iv. Corrective Steps that Will Be Taken to Avoid Further Violations

No additional corrective actions are planned.

v. Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

C. Violation C

1. Description of the Notice of Violation

"Technical Specification LCO 3.3.2, "Isolation Actuation Instrumentation," requires, in part, that actuation instrumentation channels shown in TABLE 3.3.2-1 shall be operable for the operational conditions shown in the table. TABLE 3.3.2-1, Item 7, "RHR System Shutdown Cooling Mode Isolation" requires that the RHR system shutdown cooling mode isolations for reactor vessel water level and pressure must be operable in the hot shutdown condition (operational condition 3), and if the isolations are not operable, Action 27 of the table requires that the affected system isolation valves be locked closed within one hour and the affected system declared inoperable.

Contrary to the above, sometime between 9:00 and 10:00 p.m. on July 8, 1995, and 4:29 a.m. on July 9, 1995 (a period greater than one hour), while the reactor was in the hot shutdown condition, the RHR system shutdown cooling mode pressure isolation signals were not operable in that the signals were bypassed, and action was not taken to lock the affected system isolation valves and declare the system inoperable."

2. Response to Notice of Violation

PSE&G does not dispute the violation.

i. Description of Event

The description of the event is provided in the response to Violation A above.

ii. Reason for Violation

The principal cause for the Technical Specification violation was the procedural non-compliance described in Violation A above. The causes of the procedural non-compliance are addressed in Violation A.

iii. Corrective Steps that Have Been Taken and Results Achieved

Corrective actions for this violation are described in Violation A above.

iv. Corrective Steps that Will Be Taken to Avoid Further Violations

No additional corrective actions are planned.

v. Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

D. Violation D

1. Description of the Notice of Violation

"Technical Specification LCO 3.6.1.4, "Containment Systems, Main Steam Isolation Valve (MSIV) Sealing System", requires in part, that two independent MSIV sealing system subsystems shall be operable in the hot shutdown condition. Technical Specification LCO 3.6.1.4 Action Statement permits continuation in that operational condition with one MSIV sealing system subsystem inoperable, provided the inoperable subsystem is restored to an operable status within 30 days or the reactor must be in cold shutdown (CSD) in the next 36 hours. Technical Specification LCO 3.0.3 requires that when an LCO is not met, except as provided in the associated Action requirements, action shall be initiated within one hour to

place the unit in an Operational Condition in which the Specification does not apply by placing it, as applicable, in at least cold shutdown in the subsequent 24 hours. Technical specification LCO 3.0.4 requires that entry into an operational condition may be made in accordance with the action requirements when conformance to them permits continued operation of the facility for an unlimited period of time.

Contrary to the above, at sometime between 9:00 p.m. and 10:00 p.m. on July 8, 1995, the reactor entered the hot shutdown condition (operational condition 3) from the cold shutdown condition (operational condition 4) without satisfying the requirements in Technical Specification 3.6.1.4, Technical Specification 3.6.1.4 Action Statement, and Technical Specification 3.0.3, in that two independent MSIV sealing system subsystems were not operable in that the drywell primary containment instrument gas (PCIG) system was tagged out and depressurized in preparation for outage maintenance activities, rendering both MSIV steam sealing system subsystems inoperable. In this condition, the Technical Specification 3.0.3 would not permit continued operation of the facility for an unlimited period of time; rather, it required initiation of action within 1 hour to place the reactor in cold shutdown in the subsequent 24 hours."

2. Response to Notice of Violation

PSE&G does not dispute the violation.

i. Description of Event

The description of the event is provided in the response to Violation A above.

ii. Reason for Violation

The principal cause for the Technical Specification violation was the procedural non-compliance described in Violation A above. The causes of the procedural non-compliance are addressed in Violation A.

iii. Corrective Steps that Have Been Taken and Results Achieved

Corrective actions for this violation are described in Violation A above.

iv. Corrective Steps that Will Be Taken to Avoid Further Violations

No additional corrective actions are planned.

v. Date When Full Compliance Will Be Achieved

Full compliance has been achieved.