

September 25, 1995

Mr. Leon R. Eliason
Chief Nuclear Officer and President
Nuclear Business Unit
Public Service Electric and Gas Company
P.O. Box 236
Hancocks Bridge, NJ 08038

SUBJECT: SPECIAL TEAM INSPECTION TO REVIEW SHUTDOWN COOLING BYPASS EVENT
(INSPECTION REPORT NO. 50-354/95-81)

Dear Mr. Eliason:

This letter transmits the report of the Special Team Inspection (STI), conducted from August 7-16, 1995, at the Hope Creek Nuclear Power Station. The inspection was led by Mr. James Trapp of this office and included inspectors from the Nuclear Regulatory Commission (NRC) Region I office and the Office of Nuclear Reactor Regulation. The objective of this inspection was to conduct an independent evaluation of the circumstances surrounding the July 7-9, 1995, partial bypass of shutdown cooling flow from the reactor vessel. The preliminary findings of this inspection were discussed with you and members of your staff at an exit meeting held on August 24, 1995, that was open for public observation.

The team concluded that this event was safety significant. However, the consequences of this event were minimal and this event had no direct adverse effect on the health and safety of the public or plant personnel. During the event, two required primary fission product barriers were in a degraded condition with the plant in the hot shutdown condition. The third fission product barrier (fuel cladding) appeared to be adequately protected. Further evaluation by the NRC and your staff is ongoing to determine the margin of safety for the fuel cladding during this event. Several performance deficiencies, identified during the event evaluation, were also safety significant.

The team identified several areas where operator and senior plant management performance during this event was inadequate. The failure to properly position the recirculation pump discharge valves resulted in shutdown cooling flow bypassing the reactor vessel and resulted in two inadvertent changes in the plant operational condition (i.e., mode). Both mode changes went undetected by control room operators due to the failure to properly assess plant indications. Poor communications between onshift operators and their supervisors and the failure to follow operating procedures were the root causes of this event. Inadequate procedural guidance and poor training on shutdown conditions contributed to the operators' poor overall performance.

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Mr. Leon R. Eliason

2

The failure by senior plant management initially to assess the significance of this event resulted in a delay in initiating a comprehensive event evaluation and also contributed to the failure to properly notify the NRC. Senior plant management also failed to accept the findings of the plant independent oversight organizations when assessing the significance of this event.

The significant STI findings were in general agreement with those of your root cause investigation. The corrective actions derived from your root cause evaluation and stated in the Licensee Event Report (LER) 50-354/95-16 addressed the most significant performance deficiencies. However, many previous interruptions of shutdown cooling have occurred at the plant; this event highlights the continued poor performance regarding the loss of shutdown cooling and indicates that your corrective actions in the past have been ineffective in resolving this issue.

The team noted several technical specification requirements that were not complied with during this event. The NRC decision on enforcement actions will be provided to you in a separate, future correspondence.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

No response to this letter is required. We appreciate your cooperation in this matter.

Sincerely,

James T. Wiggins, Director
Division of Reactor Safety

Docket No. 50-354

Enclosure: NRC Inspection Report No. 50-354/95-81 and Attachments

Mr. Leon R. Eliason

3

cc w/encl:

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4

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