UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

August 16, 1995

Mr. John J. Barton
Vice President and Director
GPU Nuclear Corporation
Oyster Creek Nuclear Generating Station
P.O. Box 388
Forked River, New Jersey 08731

SUBJECT: Response to Alleged Chilling Effect Letter

Dear Mr. Barton:

This is to acknowledge receipt of your July 5, 1995 letter responding to our June 6, 1995 request on alleged chilling effects at Oyster Creek.

We have reviewed your response and find it acceptable. Your immediate and followup corrective actions appear to be reasonable and should ensure that any chilling effects from the subject allegation has been eliminated.

Your cooperation with us is appreciated.

Sincerely,

Jacque P. Durr

Jacque P. Durr, Chief
Reactor Projects Branch No.4
Division of Reactor Projects

Docket No. 50-219
cc:
G. Busch, Manager, Site Licensing, Oyster Creek
M. Laggart, Manager, Corporate Licensing
State of New Jersey

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ALLEGATION DISPOSITION RECORD   Rev 3 07/13/95

Site: Oyster Creek   Section Chief (AOC): Rogge

Allegation No.: RI-95-A-0058   Date Received: 7/5/95 (GPUN Response to Chilling Effect Letter)

Acknowledged: yes   Receipt Report to SAC: 7/5/95

CONFIDENTIALITY GRANTED: Yes (No)   OI Informed: yes

IS THERE A HARASSMENT/DISCRIMINATION ISSUE: (Yes) No
(If yes, complete H&ID section on reverse)
DOES THE ALLEGATION INVOLVE POTENTIAL WRONGDOING: Yes No
DOES THE ALLEGATION HAVE POLITICAL IMPLICATIONS: Yes (No)
DOES THE ALLEGATION REQUIRE RESOURCES TO RESOLVE WHICH CAN NOT BE OBTAINED BY THE AOC: Yes (No)

If yes to any of the above, the allegation needs to go to an Allegation Panel. Otherwise, document disposition actions below.

ALLEGATION PANEL (AP) DECISIONS

Date: 7/26/95   Previous APs on issue: (Yes) / No

Chair - Cooper   Branch Chief - Durr

Section Chief (AOC) - ______   SAC - Vito

(Others) - Conner   OI Rep. - ______

DISPOSITION ACTIONS: (State specific action required for closure (including special concurrences), responsible person, ECD and expected closure documentation)

1) Panel concluded that licensee's response to 6/6/95 chilling effect letter was appropriate; will proceed w/ closeout letter to alleger
Responsible Person: Rogge / SAC   ECD: 7/31/95
Closure Documentation: ______   Completed: ______

2) DRP will provide brief response to licensee noting acceptability of response; allegation file will not be held open pending this response
Responsible Person: Durr/Rogge   ECD: TBD by DRP
Closure Documentation: ______   Completed: ______

3) ______
Responsible Person: ______   ECD: ______
Closure Documentation: ______   Completed: ______

4) ______
Responsible Person: ______   ECD: ______
Closure Documentation: ______   Completed: ______

Safety Significance Assessment: ______

Distribution:
SAC
OI
Responsible Persons
Panel Attendees
Regional Counsel

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UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

July 21, 1995

Mr. John J. Barton
Vice President and Director
GPU Nuclear Corporation
Oyster Creek Nuclear Generating Station
P.O. Box 388
Forked River, New Jersey 08731

SUBJECT: NRC INSPECTION REPORT NO. 50-219/95-11

Dear Mr. Barton:

This letter transmits the report of the resident safety inspection conducted by Messrs. L. Briggs and S. Pindale for the period May 22 through June 25, 1995, at the Oyster Creek Nuclear Generating Station. The inspectors reviewed documents, interviewed personnel, and observed activities. The inspection findings were discussed with you and members of your staff after the inspection. The inspectors found that overall plant operations were conducted safely.

During this reporting period, some activities associated with fuel movement in the spent fuel pool appeared to be driven by personnel awareness of the plant's schedule of activities and were not initially resolved by conservative decision making. Specifically, a refuel bridge job order was initiated as immediate maintenance (later changed to priority 1) and core engineering and licensed operator personnel failed to notify operations management of a bent fuel channel clip that allowed less than full seating of a fuel assembly in the spent fuel racks. The latter example resulted in a fuel assembly subsequently dropping about six inches, into the fully seated condition, in the spent full rack when it was bumped by an adjacent fuel assembly that was being moved. Appropriate, conservative action was taken by operations management when they became aware of these conditions.

The enclosed report also discusses two licensee identified violations. The first concerned control room staffing below requirements for approximately 10 seconds. The second concerned the failure to conduct quarterly functional testing of the service water radiation monitor (LER 95-01). These violations were not cited because our review found that they were promptly documented and reported to management and to the NRC, were of low safety significance, and were followed by timely corrective action. This is consistent with the NRC's policy of encouraging licensees to identify and correct violations.

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

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Mr. John J. Barton

We appreciate your cooperation.

Sincerely,

Jacque P. Durr

Jacque P. Durr, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Docket/License: 50-219/DPR-16

Enclosure: NRC Inspection Report No. 50-219/95-11 a violation of the requirements of the ODCM. However it was promptly identified by the licensee, corrective actions were prompt and appropriate, and was of very low safety significance. For the foregoing reasons, this violation is not being cited as provided in the NRC Enforcement Policy, Appendix C (1995) to 10 CFR Part 2. This LER is closed.

- Licensee Event Report (LER) 95-002 discussed the details of an unsupervised core alteration that took place on November 6, 1994. The LER accurately describes the event. This event was discussed in detail in NRC Inspection Report 50-219/95-09. Enforcement action appropriate for the event was taken in that report.

Periodic Reports

- Monthly operating report for May 1995.

5.2 Review of Previously Opened Items

(Closed) Violation 50-219/94-03-03. This violation concerned failure to take effective action to identify temporary suction strainers in pump suction piping systems and to have them removed. On March 28, 1994, the manager of system engineering issued a memorandum directing system engineers to perform a detailed inspection of their systems, to report the results, and to submit work requests to have any identified suction strainers removed during the 15R outage. Walkdown of identified systems by the licensee was completed and documented on June 3, 1994, and strainers in the core spray system were removed during the outage. No additional suction strainers were identified. The licensee did identify what is thought to be a strainer on the return line to the reactor vessel, on the discharge of the control rod drive pumps, and it will be investigated by the licensee in the future. The inspectors have verified during tours of the plant and visual inspections of various piping systems that, for those systems inspected, that all suction strainers have been removed. This violation is closed.

(Closed) Unresolved Item 50-219/94-14-02. This item concerned the primary containment pressure limit (PCPL) and was questioned during the hardened vent modification installation inspection (TI 2515/121). During the inspection, it was noted that the design pressure of the drywell had been changed from 62 psig to a design pressure of 44 psig, but the required maximum pressure allowed prior to venting the primary containment (the PCPL) under accident conditions had not changed correspondingly. This item was reviewed by Nuclear Reactor Regulation, Structural Section, and documented in a June 5, 1995, NRR, memorandum. The licensee's PCPL was determined to be within the American Society of Mechanical Engineers (ASME), Section III Code, 1977 Edition. This unresolved item is closed.

(Closed) Unresolved Item 50-219/94-20-01. This item dealt with indications of cracking in the seating surface of reactor head vent valve V-25-22. The cracking was visually identified by maintenance following lapping of the valve seat. Material Nonconformance Report (MNCR) 93-34 was initiated in January 1993 to document and resolve the issue. The MNCR disposition was to use-as-is based, in part, on an informational penetrant test (PT) which indicated that the cracks were only on the "stellite" hard facing of the valve seat and did not penetrate the valve body.

The PT had not been documented because the penetrant test had been obtained very informally. Therefore, the results of the PT were not available for review by the inspector. In addition, the inspector identified a job order which stated: "Valve body seat cracked in 14R [1993]. Replace body in 15R [1994]." This information contradicted the basis used to close MNCR 93-34. This issue was unresolved at the conclusion of inspection 50-219/94-20.

The NRC inspector questioned how the licensee determined that the cracks did not penetrate the base metal in either the valve seat or the valve body. In addition, the contradiction described above needed to be resolved. The licensee provided additional information tc the inspector following the initial inspection.

In an internal GPUN memorandum, #2450-95A-068, dated May 19, 1995, the following information was documented.

- The GPUN Valve Maintenance Committee took a proactive approach by requiring replacement of the valve body during 15R due to the limited remaining service life of the stellite seat on valve V-25-22. (The seat had been lapped several times, thus removing much of the stellite.) This information resolved the contradiction discussed above.

- Cracking of stellite valve seats is a common problem, especially when the stellite hard facing is thin due to normal wear and lapping. Industry studies and field experience have found that stellite cracks do not extend into the base metal.

GPUN also performed a visual inspection of the valve after removing it from service during 15R. They determined that the cracks did not extend into the base metal of the valve body.

The engineering justification, as documented in MNCR 93-34, was weak, but determined to be acceptable after additional questioning by the inspector. An undocumented, informational PT was used as part of the basis for determining component acceptability. Additional relevant information was not documented on the MNCR. The inspector, through additional discussions with the licensee, determined the technical bases for component acceptability, and resolved the questions on the integrity of the valve during the time it was in-service. This item is closed.

<u>(Closed) Unresolved Item 50-219/94-22-01</u>. This item concerned inadequate preventive maintenance on a non-safety related reactor recirculation pump (RRP) and whether degradation of safety related motors in storage had resulted. Although the RRP is not safety related, the licensee performed an evaluation of the preventive maintenance of stored electric motors, both safety related and non-safety related, of 100 horsepower and above to verify that they had not been degraded during storage. As of April 10, 1995, all stored motors (100 horsepower or greater) had preventive maintenance checks