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U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
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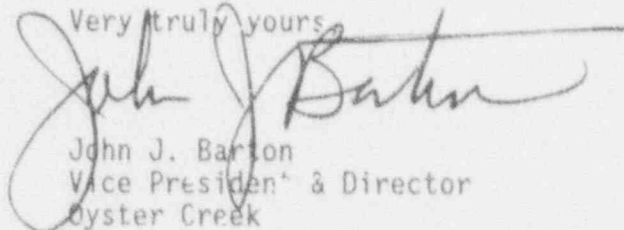
Gentlemen:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Inspection Report 92-14
Reply to a Notice of Violation

In accordance with 10 CFR 2.201, the enclosed provides GPU Nuclear's response to the Notice of Violation identified in NRC's Inspection Report 50-219/92-14.

Should you have any questions, please contact Brenda DeMerchant, Oyster Creek Licensing Engineer at 609-971-4642.

Very truly yours,



John J. Barton
Vice President & Director
Oyster Creek

JJB/BDEM:BDe

cc: Administrator, Region I
Senior NRC Resident Inspector
Oyster Creek NRC Project Manager

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Violation:

Technical Specification 6.8.1 requires that written procedures shall be established, implemented and maintained that meet or exceed the requirements of Regulatory Guide (Reg Guide) 1.33, revision 2, "Quality Assurance Program Requirements (Operation)". Reg Guide 1.33, Appendix A requires that procedures be written for surveillance testing of the containment spray system. *

Station procedure 602.3.014, revision 0, "Electromatic Relief Valve (EMRV) Pressure Sensor/Pilot Valve Control Relay - Test and Calibration," Step 6.3, provides guidance as to the location of the 'B' EMRV pressure sensor.

Contrary to the above, on July 5, 1992, two instrumentation and controls technicians failed to properly implement procedure 602.3.014 in that a test of the 'C' EMRV pressure sensor was performed with the 'B' EMRV pressure sensor taken out of service for testing. As a result of this action the 'C' EMRV was inadvertently opened for a period of about 8 seconds.

This is a Severity Level IV violation (Supplement I).

* (Violation should have stated Safety Valve Tests rather than Containment Spray System).

Response:

GPUN concurs with the violation as clarified.

The reasons for the violation are as follows:

During the 1600 to 2400 shift on July 5, 1992, two instrument and control technicians were scheduled to perform the EMRV pressure switch test and calibration surveillance. After a review of the surveillance, the Group Shift Supervisor (GSS) gave the I&C technicians permission to perform the surveillance at 1730 hours. The I&C technicians went to instrument rack RK01, which is located on the 67' platform elevation, accessed from the reactor building 75' elevation. After requesting the control room operators place the control switch for the 'A' EMRV in the off position, they performed a calibration on the pressure switch for the 'A' EMRV. Control room operators then placed the control switch for the 'A' EMRV in automatic.

While still at instrument rack RK01, the I&C technicians requested that the control switch for the 'B' EMRV be placed in the off position per step 6.3.1 of the surveillance in order to test the pressure switch for the 'B' EMRV. This instrument is located on the reactor building 51' elevation (west) and is so stated in section 6.3 of the procedure. However, the I&C technicians instead went to the pressure switch for the 'C' EMRV on instrument rack RK02, which is located on the reactor building 51' elevation (east) and proceeded to perform a calibration of the pressure switch for the 'C' EMRV instead of the pressure switch for the 'B' EMRV. Prior to performing the calibration, the I&C technicians did not verify that they were at the proper pressure switch.

The technicians then performed step 6.3.2 of the procedure which is to insure that the control switch is turned off by verifying no voltage is present at the contacts of the switch. The technicians believed they were on the proper switch when the voltmeter indicated 6.2 mvdc vice the 120 vdc expected, had the switch been energized. The location to check for voltage (connectors L1 and L2) was in a tight corner of the sensor box. It is thought that the meter may not have been making proper contact. The technicians then closed the switch isolation valve without using the surveillance procedure; therefore, they did not verify that they were closing the correct valve (step 6.3.3). Step 6.3.4 requires the test connection valve V-130-164 to be opened. However, the pressure switch for the 'C' EMRV does not have a test connection valve.

The technicians proceeded to increase pressure to test the switch, when the pressure reached approximately 1070 psig, the 'C' EMRV lifted.

The following corrective action was immediately initiated:

The 'C' EMRV was closed when the control room operator turned the control station switch to off, per procedure. The I&C technicians were instructed to return the pressure switch to service.

The corrective steps that will be taken to avoid further violations include the following:

The I&C technicians involved in this incident will be given a requalification program that will include a training session on self-checking as well as requalifying on their 'A' core OJT surveillance, and other surveillances as assigned by the I&C superintendent. The I&C technicians involved in the incident will conduct a training session for other I&C technicians on ways to avoid a reoccurrence of this type of mistake.

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The I&C technicians will not be allowed to work on safety related systems until they have been requalified by I&C supervision. This is expected to occur by November ., 1992.

In addition, an Engineering Work Request was submitted to investigate the feasibility of moving the switch terminal points to an area which would allow for easier access in testing. The engineering evaluation determined that due to environmental qualification considerations moving the switch terminal points could be inappropriate. However, there is a switch replacement modification, currently scheduled for the i5R outage, which will eliminate the need for access at the terminal points during testing activities.

Full compliance was achieved when the control room operator and I&C technicians returned the system to its normal standby configuration on July 5, 1992.