



**GPU Nuclear Corporation**  
Post Office Box 388  
Route 9 South  
Forked River, New Jersey 08731-0388  
609 971-4000  
Writer's Direct Dial Number:

March 13, 1996  
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U. S. Nuclear Regulatory Commission  
Attn.: Document Control Desk  
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Inspection Report 50-219/95-24  
Reply to a Notice of Violation

On February 6, 1996, the USNRC docketed Inspection Report 50-219/95-24. Enclosure 1 to that report contained a Notice of Violation. The attachment to this letter provides the requisite reply. If any additional information is required, please contact Ms. Brenda DeMerchant, of my staff, at 609.971.4642.

*Michael B Roche*  
Michael B. Roche  
Vice President and Director  
Oyster Creek

MBR/JJR/BD  
Attachment

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

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**Attachment I**  
**Reply to a Notice of Violation**  
**Inspection Report 50-219/95-24**

**Violation:**

Technical Specifications, 5.8.1 states that written procedures shall be established, implemented and maintained that meet or exceed the requirements of Regulatory Guide 1.33.

Regulatory Guide 1.33, Appendix A, Paragraph 9, "Procedures for Performing Maintenance", states that maintenance that can affect safety related equipment should be properly planned and performed in accordance with written procedures.

Procedure C000-WMS-7175.01, Post Maintenance Testing, Paragraph 4.1.2, states that a post maintenance test shall verify the ability of a particular component, system or structure to perform its intended function after maintenance.

Contrary to the above, on August 29, 1995, Maintenance replaced a component of a safety related system ( the average power range monitor trip bias module) and the post maintenance testing did not verify the ability of the component and system to perform its intended function.

**GPU Nuclear Reply to Violation:**

GPU Nuclear concurs with the violation as written.

On May 22, 1995, maintenance personnel replaced the trip bias unit on APRM Channel 2 to resolve an unstable trend in the Scram Clamp Set point discovered during surveillance testing. They were unable to set the 50% flow setting and the "ALL SET HIGH" light would not illuminate. The maintenance activity was halted and the original trip unit was reinstalled.

In preparation for a subsequent installation during the next scheduled APRM surveillance, different maintenance personnel performed a pre-calibration of the same replacement trip bias unit but did not correctly set the flow gain potentiometer. On August 29, 1995 the replacement module was installed and Surveillance Procedure 620.3.003 "APRM Surveillance Test and Calibration" was used for the post maintenance test. Again the "ALL SET HIGH" light would not illuminate. The "ALL SET HIGH" indication illuminates when eight series contacts ( two relays in each of the four APRM channels) are closed. It was believed that the light failure was a random relay problem in one of the APRM modules, which had been noted before. However, the actual cause of the incorrect "ALL SET HIGH" indication was the flow meter offset potentiometer of the replacement APRM trip-bias module which had not been properly set by the vendor manual, nor tested by procedure 620.3.003.

On December 31, 1995, at 1330 hours, an "APRM HI" alarm was received for APRM Channel Number 2. Maintenance was performed and APRM 2 was determined to be out of calibration. Maintenance continued and on January 2, 1996, APRM 2 was restored to full operability.

**Reason for the Violation:**

The cause of the violation was that personnel involved in the planning, production and supervisory oversight for the replacement of APRM Channel 2 trip bias unit lacked a complete understanding of the APRM flow bias circuitry. This resulted in a failure to appropriately specify post maintenance testing. A secondary cause is that personnel involved in replacing the trip bias unit (on August 29, 1995) displayed a lack of attention to detail, questioning attitude, and self-checking.

**Corrective Actions Taken and the Results Achieved:**

Upon discovery of the APRM Channel 2 flow discrepancy on December 31, 1995, the channel was declared inoperable and bypassed. Troubleshooting and calibration were done to restore the channel to operability. Additionally, a review of maintenance history was performed to ensure that no other APRM Channel flow bias signals had been adjusted since the last scheduled completion of surveillance procedure 603.3.002 "Reactor Recirc Flow Calibration", and ensure Technical Specification Compliance. No additional flow bias signals had been adjusted.

It was also discovered that on September 16 and 17, 1995, unrelated maintenance had been performed on APRM Channel 1, which is in the same reactor trip system. Having two APRM Channels inoperable in the same trip system for greater than 12 hours is a violation of Technical Specifications and was reported in Licensee Event Report 95-009.

**Corrective Steps Taken to Avoid Further Violations**

Training lesson plans on the APRM system will be revised to provide a greater level of detail regarding the APRM flow bias circuitry. These lesson plans will be part of the next cyclic training session for appropriate maintenance personnel. A revision was made to the vendor manual to provide additional guidance on flow bias adjustments. Also, the APRM Surveillance Test and Calibration procedure will be revised to include a comparison of recirculation flows for all APRM Channels at the conclusion of each test/calibration.

Finally, the personnel involved in this event will be counseled on the need for a questioning attitude, attention-to-detail and self-checking when planning and performing work.

**Date When Full Compliance was Achieved:**

Full compliance with the referenced documents was achieved on January 2, 1996, when the flow bias circuitry was properly calibrated and APRM Channel 2 was restored to full operability.