U. S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 50-219/85-35

Docket No. 50-219

License No. DPR-16 Priority -- Category C

Licensee: GPU Nuclear Corporation

100 Interpace Parkway

Parsippany, New Jersey 07054

Facility Name: Oyster Creek Nuclear Generating Station

Inspection At: Forked River, New Jersey

Inspection Conducted: October 21 - December 1, 1985

Participating Inspectors:

W. H. Bateman, Senior Resident Inspector

J. F. Wechselberger, Resident Inspector

Reviewed by:

R. J. Urban
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1/24/86
Date

Approved by:

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1-17-86
Date

Inspection Summary:

Routine onsite inspections were conducted by the resident inspectors (284 hours) of activities in progress including plant operations, outage planning, plant shutdown, outage work, plant startup, physical security, radiation control, housekeeping, surveillances, and strike preparations. The inspectors also attended a meeting to discuss the status of the hanger reinspection program, made routine tours of the control room and the power block, followed up an Unusual Event involving transportation of a potentially contaminated

worker to a local hospital, evaluated Post Accident Sampling System (PASS) operability, reviewed licensee requested emergency Technical Specification changes, and evaluated implementation of the fire protection program.

Results:

As a result of inspections performed during the one month long "10M" outage, five violations were identified:

(1) Failure of the GPUN welding program to incorporate AWS D1.1 requirements for structural welding into weld procedure specifications as discussed in paragraph 1.A;

(2) Failure of Technical Functions to adequately design/specify weld joint requirements for a structural weld as discussed in paragraph 1.B;

(3) Failure of QC and Maintenance Construction and Facilities (MCF) to follow procedures as discussed in paragraph 1.C;

(4) Failure of QC inspections to identify various discrepancies as discussed in paragraph 1.D; and

(5) Failure of various onsite personnel to properly frisk carry-along items such as clip boards, drawings, and papers when leaving the Radiation Control Area (RCA) as discussed in paragraph 4.

No new unresolved items were opened and no old open items were closed. The inspectors' followup of the Unusual Event and a reactor scram did not identify any significant problems. Licensee plans for coping with a strike were reviewed and problems resolved. Negotiations between union and management resulted in a new contract without any job action. The hanger reinspection program continued to progress with major emphasis shifting from inspections to engineering evaluations of the as-found conditions. Unresolved questions involving demonstration of PASS operability were being adequately pursued by the licensee at the end of the report period.

DETAILS

1. Outage Activities

The 10M outage, scheduled for October 18, 1985 to November 18, 1985, was started and completed as planned. During this report period, the inspectors observed preplanning, plant shutdown, outage, and subsequent startup activities. The following positive observations were made:

-- In general, communications between various divisions were observed to have improved as compared to previous outages.

-- Timely technical support from Tech Functions was observed to be significantly improved.

-- Maintenance, Construction, & Facilities (MCF) preplanning for system and equipment outages helped Plant Operations in their efforts to properly and expediently tagout components as required.

-- Job supervisors and QA/QC personnel were observed to be present in the field and involved in ongoing work activities.

-- Procedures reviewed by the inspectors were generally acceptable with reasonable QC hold points established.

-- Housekeeping degraded somewhat during the outage but was restored to an acceptable level prior to restart of the plant.

-- Startup and Test personnel were aggressive and knowledgeable. They were instrumental in identifying and resolving problems and, therefore, played a key role in the overall success of the outage.

-- Tests of intake structure concrete samples indicated concrete strength exceeded design strength.

-- Preplanning of work activities by MCF and more detailed engineering walkdowns helped to avoid schedule slippages.

-- Improvement in radiological controls and sampling enabled work without respirators in most areas of the drywell.

-- Coordination between MCF and Security was good and eliminated potential security concerns, especially for work in vital areas of the plant.

-- Remote controlled TV cameras were used to monitor drywell work activities without having to enter the drywell. This minimized the number of drywell entries.

The following inspector observations indicate areas that may require licensee evaluation to improve future performance:

-- Workmanship problems were evident as discussed later in the violations.

-- QC inspection problems were evident as discussed in the violations.

-- Quality and timeliness of MCF paperwork for turnover was a problem for a time; however, it was corrected.

-- More attention is needed to identify existing plant discrepancies as evidenced by loose and missing instrument line pipe clamps on RKO1 and RKO2 instrument racks after work on these racks was completed. Existing discrepancies were also identified with an inadequately supported cable tray and inadequate tie-wrapping of cable in the same vertical cable tray.

-- Previously leaking isolation condenser drain valves were replaced with the same type of valve and leaked again after installation.

-- The recently implemented radcon Dose Assessment System occasionally slows down entry into the RCA. The inspectors were delayed twenty minutes one evening when attempting to enter the RCA because the system was out of service. Safety related work was ongoing in the RCA at the time. It is important that inspectors and monitors, whether from the licensee organization or from outside agencies, have prompt access to plant areas to observe ongoing activities.

-- Poor planning by GPUN licensing regarding the one interim and two emergency Technical Specification change requests resulted in excessive last minute licensing effort. More licensee planning is required to avoid the need for emergency Technical Specification changes.

-- A large number of FCRs were generated. However, only a small number of these FCRs applied to the RKO1 and RKO2 EQ work, which was well planned.

The following violations were identified by the inspectors:

(A) Visual inspection of the RKO1 and RKO2 instrument racks identified inadequate structural welds. In particular, 1/2" thick by 2" wide pieces of carbon steel plate were butted together without end preparation and joined using a seal weld along one 2" side. GPUN drawings depicting rack structural work (Drawing SN15081.02-ES-04, Rev. 3 for RKO1 and SN 1508.02-ES-05, Rev. 3 for RKO2), indicate the use of 59 1/2" long pieces of this plate to aid in structural reinforcement of the racks. When the pieces were installed they were found to be 6" short. FCR C-039642 was issued to address this problem and required that the stiffener be extended by welding a 6"

long piece to the 59 1/2" long piece using a partial penetration butt weld. Thus, welds were inadequate in that seal welds had been used where partial penetration butt welds were specified.

Structural welding at Oyster Creek is done to the requirements of AWS D1.1, Structural Welding Code, which requires an effective throat of 3/16" for a partial penetration butt weld of 1/2" thick material. Following the design and joint geometry requirements of AWS D1.1 allows the use of AWS D1.1 inspection criteria which are less stringent than ASME. When the inspector questioned site welding personnel as to why a specific AWS D1.1 prequalified joint geometry was not used to accomplish this weld, he was told the weld procedure specification used to make this weld was qualified to ASME Section IX and that joint geometry per Section IX is not an essential variable. This argument was not consistent with the applicable requirements of AWS D1.1 and indicated a problem with the GPUN welding program. Additionally, the licensee specified the use of AWS inspection and acceptance criteria for the welds even though they did not meet AWS joint design criteria. The inspector subsequently reviewed the GPUN welding program and concluded the program is designed to meet the requirements of Section IX but does not address important aspects of AWS D1.1, namely, the AWS essential variable of weld joint geometry.

The failure of the GPUN welding program to address the requirements of AWS D1.1 for structural welding activities is contrary to the requirements of Criterion IX of 10 CFR 50 Appendix B and is a violation. (219/85-35-01) It should be noted that the existing GPUN welding program does address AWS D1.1 requirements for straight tee joint fillet welds.

(B) Regarding the inadequate welds discussed in (A) above, the inspector observed that engineering did not specify any weld details on FCR C-039642 for the subject weld. In light of the fact that the welding program did not address AWS D1.1 requirements, it was incumbent upon engineering to specify the design requirements for the weld. This is required by Attachment 1 to GPUN Standard MTWA-001, GPU System Welding Program and paragraph 4.2 of procedure 6150-QAP-7220.01, GPUNC Welding Manual. Based on licensee statements to the NRC inspector, apparently Stone and Webster was involved in the engineering and assumed the GPUN welding program addressed AWS requirements. The failure of engineering to specify design requirements for the weld is contrary to the requirements of Criteria III and V of 10CFR 50 Appendix B and is a violation. (219/85-35-02)

(C) Four examples of failure to follow procedures were identified as follows:

(1) A review of completed QC inspection records associated with electrical EQ work on instrument rack RK01 disclosed that some of these records were inadequate in that it was not possible to determine the specific inspection activities documented.

The procedure governing the electrical work was A15B-G1136.010, Rev. 0, RK01 Rack Modifications - Electrical. QC assigned hold points in this procedure that involved the accomplishment of multiple steps. When QC inspectors attempted to document partial inspections of these hold points by writing Plant Inspection Reports (PIRs), instead of listing the actual activities inspected, in some cases they only referred to the QC hold point number. Consequently, it was not possible, using all the available documentation (i.e. hold point numbers, PIRs, data sheets and procedures) to determine if all required inspections had been done. Examples of this problem and others are identified as follows:

(a) PIR #11025 dated 10/30/85 stated work on QC hold point 85/3002 was partially completed. QC hold point 85/3002 was assigned to step 6.8.3 in the governing procedure. Step 6.8.3 directed work be accomplished in accordance with Data Sheets 1,2,3, and 4. The QC inspector did not initial the data sheets or otherwise indicate which portion of the hold point was done.

(b) PIR #10920 dated 10/29/85 stated continuity and meggar testing work was done on QC hold point 85/2996 on cable 63-NC-0750. QC hold point 85/2996 was assigned to step 6.7.3. Step 6.7.3 directed testing of wiring on Data Sheet 5-2 steps 22-26. However, steps 22-26 do not involve cable 63-NC-0750. Additionally, no steps on Data Sheet 5-2 were initialed by the inspector involved.

(c) PIR #11166 dated 11/1/85 stated it was the final inspection of QC hold point 85/3010. There were no other PIRs issued to document work to this hold point. This hold point was assigned to step 6.10.3. Step 6.10.3 directed work to be accomplished as per Data Sheet 6. A review of Data Sheet 6 indicated two inspectors completed the required work. There should, therefore, have been an

additional PIR against this hold point. Additionally, the subject PIR did not indicate test equipment used to perform continuity and meggar testing. In fact, "N/A" was written in the space provided on the PIR tc indicate test equipment identification, thus, implying the required continuity and meggar testing was not accomplished.

(d) PIR #10799 dated 10/21/85 identified open items. A PIR is not appropriate for document open items because there is no method for closure.

(e) Steps 11 and 12 on Data Sheet 4 of the governing procedure were reinitialed on 11/7/85 but a PIR was not written to document this update.

(f) PIR #11217 dated 11/4/85 stated activity was inspected on QC hold point 85/3005 but a review of Data Sheet 5-1 indicated the inspector's initials were not on the data sheet. Additionally, this PIR allegedly documented work on steps 18 and 19 of Data Sheet 5-2 as required by QC hold point 85/3009; however, the signoff date in the governing procedure for these steps was 10/29/85, five days before the PIR date.

(g) PIR #10732 dated 10/29/85 was changed, after QC review and acceptance of the work package, to clarify certain concerns raised by the NRC inspector. Additionally, this PIR was apparently written to document the work required by QC hold point 85/3009 (See PIR #11217 above), but it did not describe the work activity.

(h) A PIR was not evident to verify QC witness of step 14 on Data Sheet 5-1 required by QC hold point 85/3009.

(i) A PIR was not evident to verify QC witness of step 24 on Data Sheet 5-2 required by QC hold points 85/2993, 85/2996, and 85/2997.

(j) PIR #11093 dated 11/2/85 did not refer to the QC hold point to which it applied.

(k) Steps 9-11 on Data Sheet 6 were required to be witnessed by QC per hold point 85/3010. They were initialed and dated on 10/31/85, but a supporting PIR dated 10/31/85 did not exist.

Exhibit #6 of GPUN procedure 6130-QAP-7210.03, Rev. 3-00, QA Mod/Ops Inspection Program states:

"Upon completion of the inspection activity...a PIR shall be filled out documenting the inspections performed... All rejectable inspections must result in the appropriate documenting of the discrepancy in process."

Paragraph 5.3 of this same procedure requires that QC supervision assure PIRs contain sufficient information to provide evidence that the objectives of the inspection have been met and items requiring a followup are identified and documented in the appropriate manner. Each of the above noted problems (a) through (k) represents an example of failure to meet procedural requirements. (50-219/85-35-03)

(2) After MCF work completion and QC inspection of modifications to instrument racks RK01 and RK02, NRC inspectors identified the following discrepancies between procedure/drawing requirements and as-built conditions that were not previously identified by MNCR, FCR, or any other licensee documentation: (219/85-35-04)

(a) FCR C-039642 to drawings ES-04 and ES-05 specified a partial penetration butt weld (described in Detail 1 (A) above). MCF only made a seal weld and not the required partial penetration butt weld.

(b) Drawings ES-04 and ES-05 required the use of 9/16" diameter by 3/4" long slotted holes in pieces 6 and 16, respectively. Round holes were used instead of the required slotted holes, resulting in a bearing connection in lieu of the intended friction connection.

(c) Bolting details on ES-04 and ES-05 show the use of a washer under both the bolt head and nut. Washers were not installed as required. Additionally, due to the approved use of shorter bolts than specified on the material list, examples of partial thread engagement of nuts on bolts were observed.

(d) Fillet welds used to connect piece 3 to existing structural steel as detailed in Section 1-1 on ES-04 were required to be 3/16" in size. The fillet welds on the front side of piece 3 were a maximum of 1/8" in size. This problem resulted because piece 3 overlap to create the proper geometry for a fillet weld was only 1/8".

(e) A three-valve manifold to level indicating instrument LI-622-916 should have been installed such that V-130-220 was the low side isolation valve and V-130-219 was the high side isolation valve. The 3-valve manifold was installed upside down, such that the tagged

valves were reversed and not in accordance with GPUN Drawing 15081.02-CC-13, Rev. 0, Instrument Rack RK01 Phase I Modification Piping Schematic.

(3) NRC review of welding records and the GPUN welding program identified an example of a job supervisor not following procedures. In particular, a weld repair record associated with MNCR 85-233 and Short Form 31529 to repair existing structural welds damaged during modification to RK01, specified MCF Production hold points to verify cleanliness, preheat, and interpass temperature prior to and during the welding. Filler metal withdrawal authorizations associated with this weld repair indicated weld rod was issued to accomplish the repair on October 27, 1985 and October 28, 1985 but on different shifts. The only signature on the weld record was dated October 28, 1985. The GPUN Welding Manual, 6150-QAP-7220.05, Rev. 0-00, in paragraph 4.2 of Exhibit 4, requires that, "Work shall not proceed beyond any hold point until the appropriate approvals have been obtained." The job supervisor on second shift October 27, 1985 did not sign the production hold points. (219/85-35-05)

(4) A review of the prerequisites associated with GPUN procedure A15B-G1136.010, Rev. 0, RK01 Rack Modifications-Electrical, and a review of plant conditions to determine if the prerequisites were met, identified a discrepancy. Paragraph 4.7.3 required that isolation condenser vents and main steam isolation valves be closed when secondary containment was required because of work around the spent fuel pool. This prerequisite was not met, nor was the procedure changed to delete it. (219/85-35-06)

Based on an emergency Technical Specification (TS) change granted to perform the EQ work defined by this and other procedures with a similar prerequisite, it was not required by TS to implement this prerequisite. Had it been required, the inspector questions how MCF could have effectively implemented it, since it (1) involved controlling equipment unrelated to the work activity and not under MCF jurisdiction but (2) did not specify a tagout.

The above four examples of failure to follow drawings and procedural requirements form a single violation of Criterion V of 10 CFR 50 Appendix B.

(D) QC inspection activities failed to identify the following deficiencies:

(1) The undersized fillet welds discussed in paragraph 1.C.(2)(d) above were inspected and accepted by QC as documented on the RK01 Structural Weld Record Sheet for Section 1-1 on drawing ES-04.

(2) The seal welds used in lieu of the specified partial penetration butt welds discussed in paragraph 1.A above were inspected and accepted by QC as documented on the RK01 and RK02 Structural Weld Record Sheets for Sections 1-1 and 1A-1A.

(3) The inadequate bolting discussed in 1.C.(2)(c) above was not identified by QC during final inspection activities. Although QC did not have a specific hold point or inspection attribute to verify proper bolting, they did have a specific hold point to witness torquing of these bolts. This inspection point, in addition to the final inspection of the completed rack work, offered QC two opportunities to identify the discrepancies.

(4) The upside down 3-valve manifold discussed in paragraph 1.C.(2)(e) above was not identified by QC during final inspection activities.

The failure of QC inspection activities to identify the four deficiencies discussed above is contrary to the requirements of Criterion X of 10 CFR 50 Appendix B and is a violation. (219/85-35-07)

2. Operational Safety Verification

2.1 Control Room Safety Verification

Routinely throughout the inspection period, the inspector independently verified plant parameters and engineered safeguard equipment availability. The following items were observed:

-- Proper Control Room manning and access control;

-- Adherence to approved procedures for ongoing activities;

-- Proper safety systems and emergency power sources valve and breaker alignment; and

-- Shift turnover.

2.2 Review of Logs and Operating Records

The inspector reviewed, on a sampling basis, the following logs and instructions for the period October 21 to December 1, 1985:

-- Control Room and Group Shift Supervisor's Logs;

-- Control Room and Shift Supervisor's Turnover Check Lists;

-- Reactor and Turbine Building Tour Sheets;

-- Equipment Control Logs;

-- Standing Orders; and

-- Operational Memos and Directives.

The logs and instructions were reviewed to:

-- Obtain information on plant problems and operations;

-- Detect changes and trends in performance;

-- Detect possible conflicts with Technical Specifications or regulatory requirements;

-- Assess the effectiveness of the communications provided by the logs and instructions; and

-- Determine that the reporting requirements of Technical Specifications were met.

The reviews indicated the logs and operating records were generally complete. No inspector concerns were identified.

2.3 The following were noted during the inspection period.

A. Reactor Scram

On November 20, 1985 at 0853 the facility experienced a reactor scram due to a main generator trip. The generator tripped as a result of the "B" phase differential current relay tripping. The turbine trip resulted from the generator trip and caus ! the reactor scram because turbine load was greater than the 40% bypass point.

Approximately one minute after the plant trip, the main steam isolation valves (MSIVs) shut causing an MSIV isolation scram. The isolation condensers were used to control pressure with the MSIVs shut. Reactor pressure was stabilized at approximately 400 psig. The isolation condensers were secured after the MSIVs were opened. Plant operators performed well in

stabilizing reactor water level and reactor pressure using the reactor water cleanup system for letdown and the isolation condensers for pressure control.

The licensee theorizes that the MSIV closure was a result of an IRM range 10 switch contact makeup when the operator manipulated the switches attempting to place the IRMs in range 9. The MSIVs will shut in range 10 if pressure is less than the low pressure bypass setpoint of 853 psig.

The licensee determined the "B" phase current transformer (CT) to be faulty. Repairs were complete on November 23 and the reactor returned to power.

B. Main Steam Line High Flow Sensors

The main steam line high flow sensor, RE-22B, failed surveillance testing on November 26, 1985 as a result of a faulty micro-switch. A plant shutdown was commenced from 636 MWe in accordance with Technical Specification requirements, but was halted at 565 MWe after the micro-switch was replaced. The instrument was declared operable after completing a successful calibration.

C. Diesel Generators

During surveillance testing on November 11, the No. 2 diesel generator (DG) tripped on reverse power, rendering it inoperable. Diesel generator No. 1 was already inoperable as a result of battery replacement. The licensee halted the movement of any heavy loads over the spent fuel pool until the diesel generators were returned to service. The No. 1 diesel generator was returned to service on November 12 upon completion of its battery replacement. The problem with the No. 2 DG was determined to be a failure of the electric governor control box. It was replaced and the No. 2 DG was returned to service.

D. Reactor Water Level Instruments

A five inch difference in the new reactor water level instruments (Yarway) has existed since the startup from the outage. This outage was to complete changes to the Yarway reactor water level instruments, among others, for the purpose of environmental qualification. Technical Functions has been assigned to investigate the disparity in the Yarway level indicators.

E. Hanger Clamp Weld Cracks

During the inspection period, the licensee discovered cracks in a weld on a hanger clamp (elevation 51' of the reactor building) on the core spray booster pump discharge piping. The licensee removed the hanger clamp and snubber while the plant was shutdown and ground the weld to determine if any propagation of the cracks had occurred into the base metal. After grinding the weld off and using a liquid penetrant test, the licensee determined that remaining base metal indications were nonrelevant. The snubber and hanger clamp were re-attached.

F. Low Reactor Water Level Channel Check

A license amendment was granted by Nuclear Reactor Regulation (NRR) in response to the licensee request regarding reactor water level instrumentation channel checks. These changes (1) revised the channel check for the low reactor water level instrumentation channels from daily checks for all channels to daily for those channels with control room indication only and (2) deleted the channel check for the low low reactor water level instrumentation channels. NRR raised additional concerns regarding the capability to verify low reactor water level instrumentation communication with the reactor vessel after surveillance testing. The licensee provided administrative controls to ensure that the instruments were properly returned to service after surveillance. Further discussions with NRR resulted in returning the instrument to service in a special manner: the high side of the instrument is valved in to produce a half trip signal, thus, verifying high side communication with the vessel. The next step is to valve in the low side of the instrument, observe the trip to clear, thus, verifying low side communication with the vessel.

3. Observation of Physical Security

During daily entry and egress from the protected area, the inspectors verified that access controls were in accordance with the security plan and that security posts were properly manned. During facility tours, the inspectors verified that protected area gates were locked or guarded and that isolation zones were free of obstructions. The inspectors examined vital area access points to verify that they were properly locked or guarded and that access control was in accordance with the security plan.

During the 10M outage, penetration sealing work was accomplished in the 4160 volt room which is a vital area. Grating preventing access into this vital area had to be removed and then reinstalled as part of this

work activity. The inspectors observed that coordination between MCF and site security was effective in ensuring proper supplementary manning of the 4160 volt room during the time the grating was removed.

No concerns were identified.

4. Radiation Protection

During entry to and exit from the radiologically controlled area (RCA), the inspectors verified that proper warning signs were posted, personnel entering were wearing proper dosimetry, personnel and materials leaving were properly monitored for radioactive contamination, and that monitoring instruments were functional and in calibration. Posted extended Radiation Work Permits (RWPs) and survey status boards were reviewed to verify that they were current and accurate. The inspectors observed activities in the RCA to verify that personnel complied with the requirements of applicable RWPs and that workers were aware of the radiological conditions in the area.

The one month 10M outage involved a substantial radcon personnel commitment. The inspectors observed that, in general, radcon personnel were responsive when called upon and were knowledgeable and helpful. Respirators were not required for most work activity in the drywell. Although this resulted in several cases of facial contamination, it was a definite improvement, in that work was generally accomplished more quickly and, consequently, with less radiation exposure.

Another improvement implemented during this outage, was the use of PCM-1 high speed personnel friskers. These friskers take approximately 20 seconds to frisk each vertical half of the body as compared to the administratively controlled two minute frisk using a RM-14. On November 6, the inspectors identified a problem associated with the use of the high speed friskers. In particular, personnel who had carry-along items in their hands would frisk one half of their body while holding the items in the hand not being frisked. Upon completion of the first half body frisk, the individuals would turn 180 degrees, shift the items to the hand just frisked, complete the second half body frisk, and then leave the RCA without frisking the carry-along items. This is contrary to the requirements of paragraph 7.2 of licensee procedure 915.26, Rev.2, Release Surveys, which states all items leaving the RCA must be thoroughly surveyed. These inadvertent failures to frisk carry-along items appeared to be fairly widespread and without thought on the part of individuals involved as to the potential for contamination on the material, much of which was paperwork that would eventually become plant records. The control point Health Physics technicians were involved with dosimetry issuance and were not able to control frisking practices. Although no actual contamination incidents were identified as part of this event, contaminated records have been found outside the RCA in the past. The failure of some personnel to comply with GPUN procedure 915.26 when exiting the RCA with carry-along items is a violation. (219/85-35-08)

During this report period, an Unusual Event was declared when a potentially contaminated worker was transported to a nearby hospital. The individual involved sustained an injury, and based upon onsite medical advice, was not moved to complete a whole body frisk. During transportation to the hospital, the radiation survey of the individual was completed; it was determined that the person was not contaminated. Shortly after this determination was made, the Unusual Event was terminated.

5. Surveillance Testing

The inspector reviewed and witnessed portions of Procedure 620.3.003, APRM Surveillance Test and Calibration, Rev. 13, dated 9/20/85, to determine if each test was technically adequate, was performed at the required frequency, and was under the control of the master surveillance schedule.

No unacceptable conditions were identified.

6. Exit Interview

At periodic intervals during the course of this inspection, meetings were held with senior facility management to discuss the inspection scope and findings. A summary of findings was presented to the licensee at the end of this inspection. The licensee stated that the subjects discussed at the exit interview did not contain proprietary information.

Also, the inspectors acknowledged receipt of the licensee's November 7, 1985 response to Violation 85-23-01, involving the use of an incorrect method for unbackseating a valve, and Violation 85-23-02, involving a failure to adhere to procedural requirements during drywell inerting. Although the responses contained adequate corrective action commitments, part of the response to Violation 85-23-01 involved a detailed discussion of event circumstances. When asked by the inspectors subsequent to the exit meeting, licensee management indicated that the intent of that discussion was only to explain the thought processes of the individuals involved; reconsideration or mitigation of the Notice of Violation was not requested. The inspectors acknowledged this clarification and stated that the corrective actions would be verified in a future inspection.