

GPU Nuclear Corporation

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U.S. Nuclear Regulatory Commission Mail Station P1-137 Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station

Docket No. 50-219

NRC Inspection Report No. 50-219/88-21

Response to Notice of Violation

In accordance with 10CFR 2.201, enclosed is GPUN'S response to Appendix A of Inspection Report 50-219/88-21, "Notice of Violation".

If you should have any questions, please contact Mr. George W. Busch at (609) 971-4909.

Very truly yours,

E. E. Fitzpatrick

Vice President and Director

Oyster Creek

EEF/GB/smz (0144A:33) Enclosure

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cc: Mr. William T. Russell, Administrator Region I U.S. Nuclear Regulatory Commission 475 Allendale Road King of Prussia, PA 19406

Mr. Alexander W. Dromerick, Project Manager U.S. Nuclear Regulatory Commission Division of Reactor Projects I/II Washington, DC 20555

NRC Resident Inspector Oyster Creek Nuclear Generating Station Forked River, NJ 08731

VIOLATION A

Technical Specifications 3.4.C states, in part, that "The containment spray system and the regency service water system shall be operable...except if one containment spray system loop and/or its associated emergency service water system loop becomes inoperable during the run mode, the reactor may remain in operation for a period not to exceed 7 days..."

Contrary to the above, while in the run mode, the reactor remained in operation for a period greater than 7 days (June 14-22, 1988) with one loop of the containment spray/emergency service water system inoperable as defined by the acceptance criteria of Surveillance Procedure 607.4.003.

RESPONSE

GPUN concurs with the violation.

The violation occurred as a result of an incorrect determination of system operability based on a containment spray/emergency service water system surveillance which was arformed with an incorrect valve line-up of the differential pressure gauge. Upon subsequent review, an error in the differential pressure reading was found, which in retrospect, invalidated the previous operability determination. The incorrect reading, which resulted in the initial determination of operability, was caused by a failure of the operator to properly align a three-way valve as required by the procedure. The root cause of this event was a complicated instrument and valve arrangement that in conjunction with unclear procedural guidance, mislead the operator in establishing the proper valve positioning.

As detailed in the subject inspection report, numerous deficiencies were identified in procedure 607.4.003 as a result of GPUN's critique of the event. Additional deficiencies were identified by the Nuclear Regulatory Commission Inspectors. This procedure has been revised to clarify direction to the operator.

Significant Changes Include:

- Separating the instructions for system I and System II into different sections of the procedure.
- Clarifying valve line-ups required at the beginning and end of each surveillance.
- Adding requirements to verify the position of each valve.
- Adding requirements to calculate overall heat exchanger differential pressure as a specific step.

Other Corrective Actions Are As Follows:

- (1) Procedure 310 was revised to clarify instructions for verifying the line-up on the "Discharge to Canal" valve.
- (2) The instrument lines have been tagged to identify proper line up.
- (3) A memo has been distributed to Plant Operations Personnel to re-emphasize managements position regarding temporary changes to procedures. Procedure changes that may be confusing to operators or may otherwise require a more detailed review shall not be implemented as temporary changes.

The subject report highlighted the need for more thorough procedure reviews. This was based on an error in procedure 607.4.003 related to the positioning of a three-way valve. It is believed that a sound procedure review program is in place for processing changes. When errors like this occur, the individual responsible is contacted in order to correct the mistake, thereby emphasizing the need for a more thorough review up front. This particular error was identified to the originator and corrected.

Full compliance will be achieved on September 30, 1988

VIOLATION B

Technical Specification 6.8.1 requires that written procedures shall be established, implemented, and maintained.

Station Procedure 124, Plant Modification Control, Paragraph 6.4.3 states, in part, that "...system operation shall not be permitted until those necessary software items and a valve lineup/system checkoff have been completed." In addition, Paragraph 6.4.4 states, in part, that "...the system can be operated provided that a current valve lineup/system checkoff has been completed by Plant Operations... This lineup/checkoff must be 'current' such that it includes any components added or removed from the system as a result of the modification..."

Contrary to the above, the modification to add differential pressure indication to the containment spray/emergency service water heat exchangers was implemented and the system placed into service on January 15, 1988 by Plant Operations without the completion of a 'current' valve checkoff sheet.

RESPONSE

GPUN concurs with the violation.

Start up testing of the differential pressure indication modification to the containment spray/ESW heat exchangers was completed on January 15, 1988 and the modified equipment was left in service following the testing. Operating procedure changes required by the modification (Procedures 310, "Containment Spray System Operation" and 607.4.003, "Containment Spray and Emergency Service Water Pump In-service Test") were revised on January 14, 1988, using the temporary procedure change process, to reflect the new valving and changes in operations and testing. The revised valve linear checkoff sheet in Procedure 310, however, was not executed when the change was approved.

The revised valve lineup checoff sheet was executed on June 24, 1988. A memo was issued by the Manager of Frant Operations to each GSS and GOS, stressing the need for the Group Shift Supervisor (GSS) or Group Operating Supervisor (GOS) to review all temporary changes for any actions which might be required, and to ensure that they are performed.

In addition to the above corrective action, GPUN is in the process of preparing revisions to the modification turnover procedures which will greatly simplify the existing system. Several modifications will be used as a trial for the new system during our upcoming 12R outage. Following the outage, the new process will replace the existing one. Each modification will have a controlling tie-in job order which identifies items required to be completed prior to placing a modified system in service. Necessary procedure changes, equipment lineup checkoff sheets and control room drawings will be identified on the job order. The GSS will, therefore, have verification that necessary prerequisites are completed prior to signing for work completion on a job order. Therefore, formal turnover per Procedure 124 can be completed at a later date.

Full compliance was achieved on June 24, 1988

VIOLATION C

Technical Specification 6.8.1 requires that written procedures be established, implemented, and maintained.

Station Procedure 124, Plant Modification Control, Paragraph 5.3.4 requires, in part, that as part of the implementation of a plant modification "The plant contact shall verify that all required control room TSC and Maintenance/Ops composite 'as-constructed' drawings have been distributed by the Technical Functions Site Supervisor prior to the turnover meeting..." The procedure requires the turnover meeting be held prior to placing the modification into service.

Contrary to the above, a modification to the Containment Spray/Emergency Service Water System was placed into service on January 15, 1988 while the control room drawing affected by the modification was not updated or posted until February 5, 1988.

RESPONSE

GPUN concurs with the violation.

The modification to the Containment Spray/Emergency Service Water System was utilized as part of surveillance performed on January 15, 1988. This was done prior to turning over the modification in accordance with plant procedures. Turnover in accordance with Procedure 124 provides the check to ensure that items such as control room drawings are in place. Since no turnover occurred prior to placing the modification in service, this check provided by Procedure 124 did not occur. The FCN posting this modification against the control room drawings was issued on February 5, 1988. The control room drawings were verified in place on March 6, 1988. Thus, when the turnover in accordance with Procedure 124 did occur on March 9, 1988, the drawings were in place.

To ensure that all required elements are in place prior to placing modifications into service, GPUN management has taken two major actions. The first action is that Operations management has issued clear direction to its personnel to aggressively take responsibility for ensuring no modifications are placed into service prior to proper reviews. These reviews are to ensure that the entire modification package has been examined in accordance with plant procedures and that all required hardware, software and training necessary to ensure proper operation has been provided.

The second action taken by management is a complete revision to Procedure 124. This revision will mandate an active participation by all departments prior to and during the installation of modifications. Prior to issuance of the job package to construction personnel, Operations will perform a thorough review of the package and define its exact requirements for all tie-ins involved in the modification. Tie-ins to the plant will not be allowed to proceed unless all required items defined by Operations, as part of this up-front review, are in fact, accomplished prior to the tie-in.

This revised procedure will be in place prior to our 12R refueling outage; however, there is insufficient time to incorporate this major revision into all work packages already planned for 12R. Thus, during 12R the new procedure will only apply to specific jobs which have been carefully selected after a complete review, by management, of all 12R outage work packages. Following the 12R outage, the revised procedure, incorporating any enhancements warranted by experience gained during the 12R outage from its limited use, will be issued as a revision to the existing Procedure 124 and apply to all future modification.

Full compliance was achieved on March 9, 1988 when the control room drawing was verified as updated and the turnover process was completed. Actions to prevent recurrence are described above.