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Director of Nuclear Reactor Regulation  
U.S. Nuclear Regulatory Commission  
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Washington, DC 20555

June 8, 1988

Dear Sir:

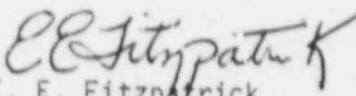
Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Response to Notices of Violation  
Inspection Report 88-04

This letter is being written to respond to the Notices of Violation contained in Appendix A of Inspection Report 50-219/88-04. GPU Nuclear's responses are contained in Attachment I to this letter. Additionally, Attachment I contains GPUN's reply to the NRC request for information contained in the cover letter for Inspection 88-04.

A review of this Inspection Report has revealed some areas of apparent misunderstanding between GPUN and NRC. Attachment II to this letter provides GPUN's perspective in an attempt to clarify the Inspection Report.

If any further information is required, please contact Mr. John Rogers of my staff at (609)971-4893.

Very truly yours,

  
E. E. Fitzpatrick  
Vice President and Director  
Oyster Creek

EEF/JR/dmd (0507A)  
Attachments

cc: Mr. William T. Russell, Administrator  
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## ATTACHMENT I

### Violation A

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

Station Procedure 130, Conduct of Independent Safety Reviews and Responsible Technical Reviews by Plant Review Group states, reviews are to be accomplished on a timely manner and that records of reviews are prepared, distributed and maintained. In addition, Station Procedure 103 Station Document Control states, "The review cycle of documents should be thorough and expeditious."

Contrary to the above, a review of Station Procedure 301 Nuclear Steam Supply System, step 2.2.1, states the pressure across the main steam isolation valves will be equalized to  $\leq 200$  psid prior to opening during a restart with the reactor vessel pressurized but, Station Procedure 201.2, Plant Heatup to Hot Standby, step 3.1.5, states the pressure across the isolation valves will be equalized to  $\leq 50$  psid prior to opening during restart with the reactor vessel pressurized. A procedure change request to correct this discrepancy written on August 18, 1987 had not been completed as of March 1, 1988.

### Response

GPUN concurs in the violation.

It was determined that procedure 201.2 was correct and needed no further revision. Corrective action was taken to complete requisite revisions to Procedure 301 and Procedure 318 "Main Steam System and Reheat System." The revision to Procedure 301 was approved on March 24, 1988, and the revision to Procedure 318 was approved on April 19, 1988. To minimize the length of time required for review and approval of procedures, the progress of procedures being revised is being tracked through the review cycle, and followup notices are periodically issued to the designated responsible person for procedures under review.

Full compliance was achieved on May 15, 1988 when Procedure 318 became fully effective.

## Violation B

Technical Specifications 6.8.1 requires that written procedures shall be established, implemented and maintained. Station Procedure 675.1.001, Revision 14, Inspection of Bergen-Patterson Hydraulic Snubbers, requires, in part, "... the components tested by this procedure meet Technical Specification requirements for operability if the following criteria are met. If any are not met consider the affected components inoperable and follow the requirements of Technical Specifications section 3.5.A.8 and Procedure 104... The snubber or its mounting hardware has no defects which would affect operation of the snubber and no defects that cannot be corrected with the snubber in place."

Contrary to the above, snubbers NQZ-1-S8, NQZ-1-S9, NQZ-1-S10, and NQZ-1-S12 had all been replaced and deficiencies in their mounting hardware corrected on or before February 2, 1988 without declaring the snubbers inoperable as required by the station procedure during the time they were out of the system for repair.

## Response

GPUN concurs in the violation.

A widely utilized practice of notifying the control room by telephone whenever a snubber change of status occurred had never been formalized. Therefore, no written records documenting the control room notification (or lack thereof) are available. A data sheet will be developed and incorporated into requisite snubber surveillance and/or maintenance procedures to require formal documentation of control room notification for snubber status changes. Full compliance will be achieved with the issuance of the revised procedures, presently projected for the fourth quarter of 1988.

### Violation C

10 CFR 50, Appendix B, Criterion 16 and Section 8.0 of the Operational Quality Assurance Plan for Three Mile Island Unit 1 and Oyster Creek Nuclear Stations require, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.

Contrary to the above, the licensee has failed to take prompt corrective action to address an angular misalignment of snubber NQ-2-S8, which exceeded manufacturer and procedural requirements. This nonconformance was identified on November 11, 1986 and again on December 16, 1987 during visual snubber surveillances conducted in accordance with Station Procedure 675.1.001. As of February 23, 1988, the nonconforming condition had still not been corrected, more than 15 months after initial identification.

### Response

GPUN concurs in the violation as corrected below.

The violation states that the angular deficiency was first identified on November 11, 1986. This is not correct. On November 11, 1986, this snubber was inspected to comply with requirements of IE Bulletins 79-02 and 79-14. Angular alignment was not a criterion for that specific inspection. The Quality Control Inspector did document an angular anomaly, but did not quantify the anomaly nor did he list the anomaly as a deficiency. Therefore, it was not evaluated as a deficiency.

The referenced angular misalignment was first quantified and documented on December 16, 1987, during the performance of the Technical Specification Surveillance for Visual Snubber Inspection. The manufacturer and procedural criterion specified angular displacements of less than 6 degrees. NQ-2-S8 was measured to be mounted at a 7 degree misaligned position. The immediate corrective actions taken at that time were insufficient to assure snubber operability. Subsequent reviews and evaluations have demonstrated that the snubber would have performed its safety related function if called upon and therefore, was not at any time inoperable. The final disposition of NQ-2-S8 was to "use as is." No corrective actions were required.

The 1987/1988 Technical Specification Surveillances were performed with new, higher accuracy measuring equipment. Previous inspections had been performed with go no-go templates. The increase in recently identified anomalies is an indication of improved methodology and not previously unacceptable performance.

To preclude recurrence of this type of event, the snubber inspection procedure will be revised to specify improved measurement tools to be utilized for angular determinations. Additionally, the snubber

inspection and testing procedures will be revised to more clearly identify the internal reporting and review requirements for identified deficiencies. Procedure issuance is presently projected for the third quarter of 1988. Full compliance was achieved with the final disposition of the nonconformance on February 26, 1988.

#### Request for Information

The cover letter for inspection 50-291/88-04 stated:

"...please include what corrective action you plan to take to address the adequacy of your programs to ensure snubber operability with regard to spherical bearing extrusions."

#### Response

GPUN has previously stated that GPUN believes that a formalized spherical bearing staking program is not necessary at Oyster Creek. As no snubbers were identified where spherical bearing disengagement had caused an inoperability, no corrective action is required.

However, as part of GPUN's policy to continually improve and upgrade existing programs, the following enhancements will be included in the snubber maintenance program:

1. The procedures for inspection of both hydraulic and mechanical snubbers will be revised to include specific acceptance criteria relating to snubber attachment hardware. A detailed sketch will be provided (as a data sheet) to simplify and clarify the requisite dimensional concerns.
2. A methodology to ensure that all criteria are considered prior to a snubber inspection will be developed and implemented. This should preclude the omission of relevant data for any given inspection, regardless of source requirements.

Finally, the need for a formalized spherical bearing staking program was re-evaluated. NRC Inspection report 88-04 on page 20 goes into detail on GPUN's lack of a staking program and references NRC Open Item 87-04-03 which is tracking the lack of a bearing staking program at Oyster Creek. IE Circular 81-05 (which is also referenced in Inspection Report 88-04) lists as a recommended action:

- "4. If loose or disengaged bushings are found at your facility, take appropriate corrective actions to ensure that complete disengagement of the assembly from the bushing cannot occur."

Please note the action does not recommend staking. Additionally, on page 1, IE Circular 81-05, states:

"The corrective actions taken by licensees have been to replace the defective struts or to "stake" the loose bushing in place. However, some of the staked bushings subsequently became loose and had to be reworked."

It appears to GPUN that NRC statements related to spherical bearings include: 1) corrective actions may be required; and 2) historically, staking has not been totally effective in preventing recurrence.

The result of the Oyster Creek re-evaluation of the need for a spherical bearing staking program has re-affirmed our original position. Staking of spherical bearings is not the most effective solution to the concern. GPUN will continue its policy to reduce the available distance that a bearing may disengage through the installation of welded shims (washers) and configuration control.



## ATTACHMENT II

NRC Inspection 50-219/88-04 contained several statements which in GPUN's opinion warrant clarification. These are presented below in the order in which they appear in the report.

Section 1 "On-Site Review of LERs", page 10 and 11: The NRC Inspector notes during the review of LER 86-35 dated January 30, 1987 that corrective actions identified in the LER were not accomplished until nearly a year after the event. The reportable condition (improperly adjusted valves) was first discovered on December 31, 1986. All requisite repairs and tests were completed on January 6, 1987. However, as the root cause could not be determined in the original 30 day submittal period, a commitment to submit a supplemental LER with appropriate corrective actions to prevent recurrence was included in the original LER. To ensure the completeness of the root cause determination, a detailed evaluation was conducted. The final evaluation report was issued May 29, 1987. The corrective action identified in Inspection Report 88-04 was contained in LER 86-35, Revision 1, dated February 25, 1988. This second submittal is dated after the December 16, 1987 corrective action date documented by the Inspector. The supplemental LER was delayed in its submittal for several reasons including several major plant problems and a work stoppage. However: 1) the plant material corrective actions were completed in seven days; 2) the corrective actions identified by GPUN to prevent recurrence were implemented and complete prior to the submittal of the revised LER. The Inspector states in the report that there was "... no indication that Maintenance Department has yet reviewed the recommendations in the independent evaluation which was completed on June 5, 1987..." The referenced independent evaluation review did in fact occur and was discussed with the NRC by the Maintenance Department. It appears the primary contributor to this misunderstanding may be GPUN's lack of documentation of an internal company meeting. The recommendations were either adopted or rejected, as appropriate. This information was provided to the Inspector by an attendee of that meeting. One evaluation recommendation was completely implemented and it was recognized during the review meeting that several facets of other recommendations were already being addressed by ongoing company initiatives. The formal documentation of GPUN's determinations relevant to the independent evaluation was docketed in the corrective action section of LER 86-35, Revision 1.

Section 9.0 "PCI Alarm", page 25: The Inspection report refers to the PCI alarm as a "Pellet Clad Interaction" alarm. Although PCI can stand for Pellet Clad Interaction, in this case the alarm annunciates for a "Pre-Conditioning Interim Operating Management Recommendations" (PCIOMR) concern, and does not indicate Pellet Clad Interaction concerns.

Section 10 "RE03 High Pressure Scram Switches", pages 26 and 27: The Inspection Report refers to the engineering effort undertaken by GPUN to address digital pressure switches which were exhibiting less than optimal performance. The report uses the word "failure" several times. As was emphasized during the inspection period and at the exit meeting, no failures had occurred. Failure, as defined in IE Bulletin 86-02, is

"... the trip point had shifted non-conservatively...such that the system could not produce sufficient differential pressure to activate the switch. This...constitutes a functional failure of the switch."

In other words, if the trip point of the switch is beyond the range of the sensor, the switch must be considered to have failed. GPUN agrees that several switches did not meet procedural acceptance criteria, and on one occasion a single sensor exceeded a Technical Specification limit by a small margin (the remaining 3 sensors were in specification). However, prudent engineering and operational decisions ensured that replacement of a suspect sensor was performed prior to any sensor failure. The Oyster Creek plant was protected by operable High Pressure Scram safety function at all times throughout this period.