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May 6, 1982

Mr. Richard Starostecki, Director
Division of Project and Resident Programs
U.S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

Dear Mr. Starostecki:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Systematic Assessment of Licensee Performance (SALP)

Your letter of April 7, 1982 provided, for our review and response, a draft Systematic Assessment of Licensee Performance (SALP) report concerning activities conducted at the Oyster Creek Nuclear Generating Station for the period November 1, 1980 through October 31, 1981. Attachment I to this letter provides our responses to the maintenance and surveillance areas which were classified as areas of weakness.

In addition to our specific responses concerning those two areas, we are taking this opportunity to provide comments on the other areas which were evaluated. The additional comments, also contained in Attachment I, are provided to help meet the SALP objective of furthering NRC's understanding in how the licensee management directs, guides, and provides resources for assuring plant safety.

Very truly yours,

A handwritten signature in cursive script that reads 'Philip R. Clark'.

Philip R. Clark
Executive Vice President
GPU Nuclear Corporation

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cc: Mr. Ronald C. Haynes, Administrator
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
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NRC Resident Inspector
Oyster Creek Nuclear Generating Station
Forked River, NJ 08731

ATTACHMENT I

Subject: Responses and Comments to the NRC Systematic Assessment of Licensee Performance (SALP)

Evaluation Period: November 1, 1980 Through October 31, 1981

Summary of NRC Evaluation:

<u>FUNCTIONAL AREAS</u>	<u>OYSTER CREEK NUCLEAR GENERATING STATION</u>		
	<u>CATEGORY 1</u>	<u>CATEGORY 2</u>	<u>CATEGORY 3</u>
<u>1. Plant Operations</u>		X	
<u>2. Radiological Controls</u>		X	
<u>3. Maintenance</u>			X
<u>4. Surveillance (Including Inservice and Preoperational Testing)</u>			X
<u>5. Fire Protection and Housekeeping</u>		X	
<u>6. Emergency Preparedness</u>		X	
<u>7. Security & Safeguards</u>		X	
<u>8. Refueling</u>		X	
<u>9. Licensing Activities</u>		X	

Category Definitions:

Category 1: Reduced NRC attention may be appropriate. Licensee management attention and involvement are aggressive and oriented toward nuclear safety; licensee resources are ample and effectively used such that a high level of performance with respect to operational safety or construction is being achieved.

Category 2: NRC attention should be maintained at normal levels. Licensee management attention and involvement are evident and are concerned with nuclear safety; licensee resources are adequate and are reasonably effective such that satisfactory performance with respect to operational safety or construction is being achieved.

Category 3: Both NRC and licensee attention should be increased. Licensee management attention or involvement is acceptable and considers nuclear safety, but weaknesses are evident; licensee resources appeared strained or not effectively used such that minimally satisfactory performance with respect to operational safety and construction is being achieved.

1. Plant Operations - NRC Evaluation

During the previous assessment period, (August 1, 1979 - July 31, 1980), several violations were identified involving procedural inadequacies, inadequate mechanisms for issuance of management instructions, and failure to follow procedures. Of particular importance was an incident involving failure to remove control rod interlock bypass jumpers prior to completion of control cell fuel reload. Programmatic weaknesses were identified in the area of adherence to management controls procedures at the lower management and supervisory levels, and in the area of meeting commitments to the NRC. An improving trend was noted as licensee management responded in a positive manner to address the identified weaknesses.

This area was under continuing review by the resident inspector for the current (November 1, 1980 - October 31, 1981) assessment period. Twelve operations related violations were identified. Failure to follow procedures resulted in four Severity Level V violations. Inadequacies in the area of administrative controls resulted in one Severity Level V violation when PORC meeting reports were not properly distributed, and two Severity Level VI violations involving failure to properly review or revise operating and surveillance procedures. Two Severity Level IV violations were identified involving failure to recognize a containment integrity violation when an isolation valve failed during testing, and recurrent violations of technical specifications when containment spray compartment water tight doors were left open. Failure to report an unplanned radioactive release and inadequate corrective action on recurrent spills of radioactive liquid resulted in two Severity Level IV violations. One Severity Level II violation involving vacuum breaker blockage was indicative of inadequate controls over activities affecting plant operations, and sometimes inadequate tours of the plant by operations personnel. Thirty-two licensee event reports were related to the operations area. Reports were generally timely and accurately identified the causes and corrective actions needed.

Improvements have been noted in management involvement in this area. The licensee has implemented a Nuclear Assurance Department Operations Support Program. The program involves the assignment of an Assistant to the Plant Operations Director and Shift Assistants who are tasked with reviewing plant operations and making recommendations for improvement in the areas of procedural adequacy, procedural adherence, and control of activities that have an impact on operations. Also, corporate management has issued policy statements stressing verbatim compliance with operating procedures and has begun vigorously enforcing the policy.

This program has resulted in many improved procedures, improved procedural adherence, improved operation awareness and understanding of plant activities, improved followup of operations identified maintenance concerns, and improved operator morale. The program has relieved some management and supervisory personnel of administrative burdens, allowing more timely and thorough reviews of activities.

The development of a "programs and controls" group has improved the scheduling and prioritization of work activities and the coordination between maintenance and operations.

Some problems still exist with operator knowledge of regulatory requirements. These problems are evidenced by the following:

- (1) Failure to recognize malfunction of a TIP in-shield limit switch as a degradation of containment integrity.
- (2) Failure to recognize failure of a reactor building ventilation isolation valve as a degradation of containment integrity.
- (3) Interpretation of exceeding a peaking factor limit during a power transient as a "Safety Limit Violation".

Licensee corrective and preventive actions have been generally acceptable and indicative of a responsiveness to NRC concerns.

Conclusion - Category 2

Board Recommendations - None

GPU Nuclear Corporation Comments:

The third paragraph in the above evaluation references a Nuclear Assurance Department Operations Support Program. This is a misnomer. The comment is made in order to avoid confusion between activities conducted by our Nuclear Assurance division and this program.

The program consisted of temporarily assigning experienced personnel, from other divisions within GPUNC, including the Nuclear Assurance Division, to aid in the site specific activities of the Operations, Maintenance and Plant Engineering departments of the Oyster Creek Division. These specific assignments were made on a temporary basis to fill vacant positions. At the present time, the temporarily assigned personnel have returned to their respective divisions. Continuity of the program will be based on an overall evaluation of the program and permanent personnel have been placed in many positions.

With regard to the statement in the last paragraph of the evaluation that some problems still exist with operator knowledge of regulatory requirements, a comprehensive formal refresher training program has been developed for Operations Shift Supervisors in the area of Technical Specification and regulatory requirements. The results achieved by a program of this nature would not be observable in the short term, but are expected to result in improvements in this area.

2. Radiological Controls - NRC Evaluation

The previous assessment period identified several areas of major concern. Programmatic problems included inadequate staffing, use of personnel not meeting ANSI N18.1-1971 standards, procedures inconsistent with Technical Specifications, and poor control in the area of transportation of radioactive waste. Nineteen violations were identified and one civil penalty was assessed for inadequate radiation work permit procedures. An improving trend was noted in the latter part of the assessment period when action was taken to upgrade the radiation protection training program, increase the size and quality of the radiation protection staff, and implement organizational changes to put direct management attention in the areas of radwaste operations and shipping.

During the current assessment period, four inspections were performed by region based inspectors in the area of radiological controls. One included a review of the radwaste management program and two included review of effluent monitoring and control. In addition, one regional office evaluation of a State of Nevada burial site inspection, and one investigation of NAC-1E shipping cask event were conducted. Selected activities in this area were under continuous review by the resident inspector. Six violations, two Severity Level III's associated with radioactive waste transportation, two Severity Level IV's associated with control of high radiation area access, and two Severity Level V's associated with dosimetry issue procedures and control of procedure changes were identified. These items were not repetitive or indicative of programmatic breakdowns. Corrective actions were timely.

Two licensee event reports identified unmonitored uncontrolled liquid releases. Four operations related event reports identified failures to monitor gaseous effluents due to sample system breakdowns. The events were properly classified and reported.

Management involvement in this area is evidenced by the major reorganization of the radwaste management program and generally well defined procedures. However, lack of formal approval of Radiation Control Technician training program remains a long-standing issue. The General Employee Training Program contributes to fair adherence to procedures and minor numbers of personnel errors. The plant staffing appears to be adequate and the radiological engineering reviews show evidence of adequate planning and technically sound approaches to problems.

Conclusion - Category 2

Board Recommendations - None

GPU Nuclear Corporation Comments:

The radiological Field Operations Training Program, referred to in the fourth paragraph, has now been submitted for NRC review and approval. As you are aware, until NRC approves this program, each member of the radiation protection organization, for which there is a comparable position described in ANSI N18.1-1971, meets or exceeds the minimum qualifications specified therein.

3. Maintenance - NRC Evaluation:

Three inspections during the previous assessment period identified no violations. Three of four maintenance related event reports involved personnel error. The assessment concluded that the licensee had a viable maintenance program with no major programmatic weaknesses.

During the current assessment period, one region based inspection and routine inspection by the resident inspector identified no violations. In an effort to improve the maintenance program, the licensee has assigned a full time preventive maintenance manager and a full time corrective maintenance manager reporting to the plant maintenance manager. This has placed increased management attention on the control of maintenance activities; however, there is a lack of corporate and plant management involvement in the review and prioritization of outstanding maintenance items and an apparent understaffing in maintenance departments. There is a large backlog of outstanding work orders and frequent instances where job orders are closed out when only temporary repairs are completed, or where job orders considered to be of minor importance are cancelled.

In addition to a backlog of maintenance orders, there is a large number of long-standing lifted leads and jumpers. These have not been closed because of incomplete maintenance modifications which did not include permanent removal of abandoned components, or the need for further engineering review.

The preventive maintenance program is being expanded and crews dedicated specifically to preventive maintenance are being formed. This program presently involves primarily instrumentation and lubrication. Maintenance records are reviewed by a preventive maintenance engineer who is developing machinery history records, but this program has not yet been developed to the point that maintenance trend analysis can be performed.

In addition to marginal maintenance history records, the availability of current equipment data is a weakness. Controlled files of equipment data with component model and serial numbers, parts lists, and engineering drawings are not always up to date. For example, the controlled valve list does not reflect the fact that the reactor building to suppression chamber air operated vacuum breakers were replaced with valves made by a different manufacturer in 1979.

The licensee's response to NRC initiatives is sometimes delayed. For example, corrective actions on a 1977 IE Circular relating to fuse coordination in Standby Liquid Control system Squib firing circuits, a 1979 IE Circular relating to defective diesel fire pump starting contractors, and a 1979 IE Circular on Limitorque valve operator locking devices were not completed until the NRC expressed concern for lack of responsiveness.

An event during the assessment period involving blockage of torus vacuum breaker valves by contractor erected scaffolding resulted in a Severity Level II violation and assessment of a civil penalty. Another event involved an unmonitored airborne release of radioactive material from the radwaste building ventilation system. These events are indicative of inadequate control of contractor work. After the assessment period, an event involving improper assembly and testing of a torus vacuum breaker valve was discovered. The action resulted in one torus vacuum breaker being inoperable for about 18 months during reactor operation. This event, which is still under review by the NRC, indicates that a strengthening of management control and procedural control over maintenance activities is necessary.

The licensee has implemented a program of increased management involvement in maintenance activities. In addition, recent staffing changes which have placed individuals with extensive maintenance background in upper-level management positions have resulted in an improving trend in this area.

Conclusion - Category 3

Board Recommendations - Increased inspection effort by the resident inspector.

GPU Nuclear Corporation Comments:

The evaluation period (November 1, 1980 through October 31, 1981) coincides with the reorganization of our Maintenance Department in September 1980 and as such, covers a transition period. Current activities now meet most of the goals of the reorganization and satisfactorily address many of the concerns of the above evaluation. The following paragraphs provide examples of how the reorganization has effected positive changes which, toward the end of the evaluation period and subsequent thereto, have become clear:

The second paragraph of the evaluation contains the statement "... there is a lack of corporate and plant management involvement in the review and prioritization of outstanding maintenance items ...". Procedure No. 105 "Conduct of Maintenance" ensures that management reviews and prioritizes each job order. The prioritization of job orders has been in effect since January of 1981 and consists of assigning one of four priorities. "Urgent 1" is the most immediate priority and indicates that work should be started within one day. This priority includes emergency maintenance initiated by the Group Shift Supervisor and other work considered likely to cause any of the following conditions within three days:

1. Personnel injury
2. Significantly increased contamination or radiation hazard
3. Unplanned, uncontrolled release of radioactive material to the environment in excess of normal release rates
4. Significant damage to safety-related equipment needed for safe plant shutdown
5. Violation of Technical Specifications
6. Immediate plant shutdown or load reduction

The remaining three categories involve problems of a lesser severity and guidance is given in the procedure for assigning priorities.

The second paragraph also refers to "... an apparent understaffing in maintenance departments ...". We have increased our first line supervisor to worker ratio. Currently, our average ratio is one supervisor per ten to twelve workers. The key maintenance positions are now filled and implementation of the desired program is being effected. We believe that our present emphasis on more effective use of supervision, emphasizing supervisor presence on the job site and better planning, in addition to the improved supervisor to worker ratio, will help effect the desired improvements.

The last sentence in the second paragraph states "There is a large backlog of outstanding work orders and frequent instances where job orders are closed out when only temporary repairs are completed, or where job orders considered to be of minor importance are cancelled." There are a large number of outstanding work orders, many as a result of our increased efforts to identify what work needs to be accomplished. However, as identified above, all job orders are prioritized according to specified criteria and the majority of outstanding job orders are in the minor category.

With regard to job orders being closed out inappropriately, Procedure 105 currently requires that a job order may only be cancelled by the applicable Maintenance Supervisor after obtaining concurrence of the initiating department supervisor. The procedure also identifies when temporary repairs are effected or further modification to the existing system is required, the temporary repair job order may be closed out. A new job order is initiated for execution when materials and/or the modification package is available.

With regard to the large number of long-standing lifted leads and jumpers referred to in the third paragraph, we have recently completed a review of and dispositioned all lifted leads and jumpers where possible. The unresolved remaining items have been identified and are being referred to engineering for permanent resolution.

The fourth paragraph in the evaluation discusses the preventative maintenance program. We feel this area has been greatly improved, since reorganization in September 1980. The present program includes electrical, mechanical, instrumentation and lubrication activities. Maintenance history cards are now updated whenever corrective or preventative maintenance is performed. Although past history of maintenance may, in some cases, be unretrievable, current practices will ensure that future trend analysis will be achievable.

Our responsiveness to NRC initiatives is now coordinated through the Licensing Department. Each item is assigned to the cognizant department and tracked by a formal program until completion of the assignment is effected. Outstanding items are brought to the attention of upper management and a summary report is provided to the Office of the President on a monthly basis. The current program should help ensure that events such as the examples cited in the evaluation will not be of a recurrent nature.

With regard to control of contractor activities, our corrective actions, as you are aware, are described in our response to the Notice of Violation dated September 21, 1981. The controls imposed have had a positive effect in that potential problems are identified and corrected prior to conducting work activities.

4. Surveillance - NRC Evaluation

During the previous assessment period, six routine unannounced inspections by region based inspectors, one Performance Appraisal Branch Inspection and routine inspection by the resident inspector identified three violations. The licensee had failed to perform surveillances on three occasions.

During the current assessment period, two region based inspections, one regional based team inspection, and routine resident reviews identified eight violations. The violations involved failure to conduct Technical Specification and ASME Section XI testing, inaccurate calibration, calibration and testing without procedure, and inadequate calibration data and procedural changes.

Corrective action was agreed to in an Immediate Action Letter dated April 8, 1981. The licensee agreed to upgrade his inservice test program to meet the requirements of ASME code Section XI by January 1, 1982. After the assessment period, region based inspectors found that the licensee had not completed all corrective action, in that a program for valve testing was not fully implemented. The licensee has since submitted a revised completion schedule to NRC:RI. The licensee stated that operational commitments and manpower shortages were the reasons for not meeting the commitments. The high number of violations and the failure to meet commitment dates without notification, indicate weakness in licensee management control in this area.

The large number of event reports resulting from instrument drift and the long standing nature of this issue indicates a need for high level management involvement in this area to achieve technically acceptable resolution. Violations resulting from missed surveillances, in particular a Severity Level IV violation involving failure to survey Emergency Service Water pumps following unacceptable surveillance on redundant pumps, indicate a need for more management attention in review of surveillance programs and assuring unambiguous acceptance criteria.

This need is further amplified by a violation that occurred after the assessment period. Three successive failures of an isolation condenser valve during operability testing followed by two successful operations of the valve, with no followup investigation to determine the cause of the failures, was interpreted by a member of the management staff as acceptable component performance.

Conclusion - Category 3

Board Recommendations - None

GPU Nuclear Corporation Comments:

Several violations that are referenced in the above evaluation involved a failure to comply with the surveillance requirements of recently approved Technical Specification changes. Our practice had been that follow-up to Technical Specification changes, such as the drafting of procedures, was not initiated until after NRC had approved the change. At present, the Surveillance Testing Program is administered by the Plant Engineering Department and compliance to Technical Specifications is accomplished through the maintenance of the surveillance testing schedule and implementing procedures.

To improve the implementation of Technical Specification changes, Plant Engineering will review all pending Technical Specification Change Requests and assure that all aspects relative to the specific changes are prepared in anticipation of approval. Once approved, the draft procedures will be reviewed again for changes, which may have occurred due to NRC review, and cycled through our internal cycle for final approval and implementation. Under this program, a change to Technical Specifications should be implemented within 30 days after issuance.

As you are aware, the common NRC practice of making Technical Specification changes "effective upon date of issuance" has been addressed by us in previous correspondence as being impractical to implement. We request that all changes to Technical Specifications become effective 30 days after receipt by the licensee unless requested otherwise.

In addition to the above planned actions, Plant Engineering has instituted training in the area of Technical Specifications. All engineering personnel will be required to attend. The classroom instruction will be presented by the BWR Licensing Manager and is scheduled to be conducted during May of 1982.

An integrated training program is being developed to educate each member of the Plant Engineering staff with regard to general BWR knowledge. Specific system responsibility will be assigned to individuals who will be expected to acquire knowledge comparable to operations personnel for the systems assigned to them. This is expected to raise the overall system level knowledge with regard to plant operations to a level considerably higher than before. Training in the specific system areas is expected to begin in July of 1982.

We feel the violations referenced in the evaluation regarding the Emergency Service Water Pumps and the Isolation Condenser Valve do not indicate a programmatic weakness in the surveillance program. The decision to declare the Emergency Service Water Pumps operable was based on previous knowledge and experience of system performance. Management's decision was based on knowledge that should have been incorporated into the procedure; however, in absence of procedure criteria, the pump should have been declared inoperable. With regard to the Isolation Condenser valve operability, the cause can be attributed to poor judgement. This event has been discussed with plant operations personnel and management direction to make such judgement conservatively from a safety standpoint has been reemphasized.

5. Fire Protection and Housekeeping - NRC Evaluation

Three inspections by region based inspectors and one Performance Appraisal Branch inspection during the previous assessment period identified no major programmatic weaknesses. Two violations were identified involving storage of combustible material in safety related areas.

During this assessment period, general fire protection activities and housekeeping were under continuous review by the resident inspector. No programmatic inspections were performed. No violations in this area have been identified. Two Licensee Event Reports were submitted; one, the result of mechanical failure of a fire hydrant, the other involving personnel error when a cable penetration barrier was found in a degraded condition.

Management involvement in this area is evident by the assignment of a full time fire protection engineer, recent procedural revisions to provide better control of combustible material, and improved surveillance of fire barriers.

There were considerable problems causing delays in the installation and testing of a storage tank and pumping system to provide an alternate source of water to the fire protection system.

Several recent events involving wetting and ultimate impairment of safety related electrical equipment have demonstrated inadequacies in the original fire protection safety evaluation. High level management attention to this problem since the end of the assessment period has resulted in an extensive survey of plant systems and a program to waterproof and protect electrical components.

Housekeeping has improved during this assessment period as a result of more management attention. Radiological housekeeping conditions are generally acceptable with no significant NRC inspection findings in this area. Poor general plant cleanliness and appearance; however, continues to reflect poor plant staff attitudes and lack of professionalism/pride. An improving trend has been noted as a result of increased management attention.

Conclusion - Category 2*

Board Recommendations - none

*This rating is assigned without regard to the licensee's position on 10 CFR 50, Appendix R provisions.

GPU Nuclear Corporation Comments:

As a result of increased management attention in the area of housekeeping, we feel there has recently been considerable improvements in plant cleanliness and appearance. We feel the continued emphasis will elevate the pride of the entire plant staff.

6. Emergency Preparedness - NRC Evaluation

No programmatic inspections were conducted in this area during the previous assessment period.

During the current assessment period, an emergency preparedness drill was observed by the resident inspector. The drill indicated weaknesses in the licensee's ability to implement the provisions of a revised emergency plan issued about one week prior to the drill. The licensee recognized the deficiencies which were also identified by several internal audits. An intensive upgrade program, which included significant increases in emergency planning staff, further emergency plan and procedure reviews, and intensive training, was begun.

An NRC team appraisal of emergency preparedness was conducted in January 1982 after the end of the assessment period. The appraisal identified significant weaknesses requiring corrective actions. These weaknesses included: required upgrading of emergency response facilities; improved capability for post accident sampling of stack effluent, reactor coolant, and containment atmosphere; emergency procedure improvement; and better definitions of the training program for emergency response personnel. The licensee's proposed corrective actions were discussed in a Confirmatory Action Letter dated February 18, 1982.

An NRC team observation of a major emergency preparedness exercise was conducted in March 1982. This observation determined that the licensee had demonstrated the capability to implement the provisions of the emergency plan to adequately protect the public health and safety during an accident, however, areas for improvement were noted and discussed with the licensee.

The licensee failed to meet the February 1, 1982 deadline for installation of a Public Notification System and was issued a Severity Level III Notice of Violation. Forty-five warning sirens were installed and tested by March 5, 1982. The final siren was installed and tested on March 11, 1981.

Conclusion - Category 2

Board Recommendations - None

*This categorization has been assigned on the bases of additional information developed after the assessment period and without regard to resolution of the outstanding issue of the Confirmatory Action Letter of February 18, 1982.

GPU Nuclear Corporation Comments:

The last paragraph in the above evaluation contains two minor errors concerning the installation dates of our warning sirens. As we indicated in the response to the Notice of Violation, forty-five (45) warning sirens were installed and tested by February 26, 1982. The final siren was installed and tested on March 5, 1982. Since the SALP evaluation, we note that NRC, by their letter of April 28, 1982, has evaluated our overall response to this matter and advised us that they plan no further action.

7. Security and Safeguards - NRC Evaluation

During the previous assessment period, two routine inspections by region based inspectors, routine review of selected areas by the resident inspector, and one inspection by the Performance Appraisal branch identified no violations or evidence of programmatic weaknesses. During one inspection, allegations by a former security watchman, which had been published in a local newspaper, were reviewed but could not be substantiated.

During the assessment period, two routine inspections by region based inspectors identified 7 violations. Six Severity Level IV violations were identified involving failure to secure a vital area barrier, use of improper identification badges, failure to conduct key audits, failure to perform explosives detector performance tests, inadequate lighting in two areas, and failure to retain certain records. Licensee's corrective action on these items, which were identified in one inspection, were discussed in a management meeting during this assessment period.

One Severity Level V violation involving failure to properly control a vehicle within the protected area was identified in a subsequent inspection. The large number of violations are not indicative of major programmatic breakdowns. An inspection conducted since the end of the assessment period (December 7-11, 1981) identified no similar problems. Management attention is demonstrated by the prompt action to correct and prevent recurrence of the identified problems. Site management is generally responsive to security program requirements. Required reviews, audits and records are generally complete and show involvement by Corporate management. The security organization is well staffed with well defined responsibilities and adequately trained personnel. Procedural adherence is good with infrequent personnel errors.

Conclusion - Category 2

Board Recommendations - None

GPU Nuclear Corporation Comments:

None.

8. Refueling and Major Outage Activities - NRC Evaluation

During the previous assessment period, one region based inspection and frequent resident inspector reviews of refueling and outage activities identified two violations involving procedural inadequacies and procedural adherence. One of the violations involved a major breakdown of administration controls causing failure to remove control rod interlock bypass jumpers prior to control cell fuel reload. This violation received high level management attention by the corporate General Office Review Board and the Independent Safety Review Group.

During the current assessment period, one region based inspection of post refueling testing and reload analysis was conducted. No violations were identified.

One scheduled and frequent unscheduled maintenance outages occurred during the assessment period. Considerable improvements in scheduling and coordination of outage activities were noted. This is due primarily to the assignment of a full-time Programs and Controls Manager who oversees outage planning. Scheduling activities generally addressed key outage and outage recovery items.

A completed modification, under this program, will be accepted based on the completion of preestablished conditions. The conditions specified for each modification will be formulated at a planning meeting after construction activities have been authorized. Preestablished conditions being addressed include:

1. Training completed for operations personnel concerning the installed modification
2. All applicable operating procedures revised
3. Required spare parts identified
4. Preventative Maintenance Procedures written and Preventative Maintenance schedule updated
5. All applicable drawings revised
6. Surveillance procedures and the Master Surveillance schedule revised

The interfacing departments or divisions assigned responsibility for completion of the preestablished conditions will meet formally to verify and sign-off that the modification can be put into service.

The following departments will be involved as appropriate:

- | | |
|---------------------------------|--------------------------------|
| 1. Plant Operations | - Oyster Creek Division |
| 2. Plant Maintenance | - Oyster Creek Division |
| 3. Plant Engineering | - Oyster Creek Division |
| 4. Project Engineering | - Technical Functions |
| 5. Start-Up and Test | - Technical Functions |
| 6. Maintenance and Construction | - Maintenance and Construction |
| 7. Training and Quality Control | - Nuclear Assurance Division |
| 8. Configuration Control | - Technical Functions |

Procedure No. 124 "System/Equipment Turnover After Modification" is presently being reviewed and revised to address the above program. Additional procedures, if deemed necessary, will be developed.

In addition to this program, Plant Engineering will assign an engineer as the "plant contact" for each modification authorized through the Technical Functions division. The intention of the plant contact is to provide Plant Engineering awareness and follow-up of the modification such that appropriate documents, i.e., operations, maintenance, and surveillance procedures, vendor's manuals spare parts list, etc., are in the development stage as the modification is progressing.

Some problems in the area of control of contractor work were noted as evidenced by one violation involving blocking of torus vacuum breakers by contractor erected scaffolding and an event involving an airborne release of radioactive material from the radwaste building ventilation system.

One region-based inspection conducted after the assessment period, identified some weaknesses in the area of control of design changes and modifications. These findings, which are under review by NRC management, indicated that the management of the design changes and modification program is very fragmented with poor central control and review. Many procedures for the program are in draft form and many are still being prepared.

Training on modifications completed during outages is sometimes delayed until just prior to startup, and drawing revisions are sometimes delayed. This, together with insufficient management involvement in design change program, results in an occasional lack of coordination between engineering, construction, and operations staff during turnover of systems to operations control and in occasionally late implementation of revised procedures.

The licensee has a well staffed corporate technical engineering group. This group is still gaining site specific familiarity resulting in considerable reliance on contractors for engineering support.

Conclusion - Category 2

Board Recommendations - In light of the planned extended outage involving numerous and diverse modifications, increased inspection activity should be devoted to outage activities particularly during the early portion of the outage.

GPU Nuclear Corporation Comments

We have had under development since early 1981, an integrated and improved system of controls for work being done in the plant. Improvements have been and are being implemented on an individual basis. The improved system is scheduled to be in effect prior to the upcoming outage. The system will require a formal turnover to plant operations of all newly installed modifications.

9. Licensing Activities - NRC Evaluation

No specific assessment of licensing activities was performed during the prior assessment period; pertinent issues were included in other functional areas.

Licensing activities during the current assessment period included miscellaneous Technical Specification changes, a review of TMI Task Action Plan items, a major license amendment changing the license to GPU Nuclear Corporation, and replacement core spray sparger design.

The licensee's performance and management capabilities were generally adequate; however, the timeliness of responses has been poor with a two to three month time delay being the norm. Details of submittals are usually coordinated with the staff beforehand to establish requirements and clarity, and are generally good quality. However, some submittals relative to the Systematic Evaluation Program (SEP) and the TMI Task Action Plan (NUREG-0737) were not always complete and resulted in frequent requests by NRC for additional information. The licensee and his contractors have demonstrated adequate working knowledge of regulatory requirements and excellent level of technical competence. The licensee's staffing is generally adequate, but in view of planned modifications and possible SEP upgrade requirements, may require increases.

Conclusion - Category 2

Board Recommendations - None

GPU Nuclear Corporation Comments:

The third paragraph of the evaluation states, "... the timeliness of responses has been poor ...". While there have been cases where our response has been later than requested, we believe that a large factor in this has been the volume of requests and NRC's practice of setting unrealistic response dates. Requests made for information frequently require complex studies or analyses to be performed before an adequate response can be prepared, reviewed, and approved by upper management. We will continue to respond in a timely manner and to formally request extensions where appropriate.