



**GPU Nuclear**

P.O. Box 388  
Forked River, New Jersey 08731  
609-693-6000  
Writer's Direct Dial Number:

February 17, 1983

Mr. Richard W. 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  
License No. DPR-16  
Inspection Report No. 50-219/82-29

This letter is submitted in response to your letter dated January 18, 1983 regarding the findings of the routine resident safety inspection conducted by Messrs. C. Cowgill and J. Thomas on November 12 - December 31, 1982.

Pursuant to the provisions of 10 CFR 2.201, attached are our responses to the violations cited in Appendix A of your correspondence.

If there are any questions regarding the enclosed information, please contact me or Mr. Michael Laggart of my staff at (609) 971-4643.

Very truly yours,

Peter B. Fiedler  
Vice President and Director  
Oyster Creek

PBF:jal  
Attachment

cc: Mr. Ronald C. Haynes, Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

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

Attachment

The following information provides a response to the Notice of Violation cited in Appendix A of the US NRC letter dated January 18, 1983.

Violation A:

- A. Technical Specification 6.8.1 requires that written procedures be established, implemented and maintained that meet or exceed the requirements of Appendix "A" of NRC Regulatory Guide 1.33-1972.

Regulatory Guide 1.33-1972 requires that shift and relief turnover be covered by written procedures.

Administrative Procedure 106, Revision 21, June 1, 1982, "Conduct of Operations," requires that proper and conservative turnover of shift responsibilities be conducted. Pertinent information shall be transferred between parties and turnover checklists shall be used as guides and signed prior to the oncoming personnel assuming the shift duties.

Contrary to the above, on November 16, 1982, shift turnover was not properly conducted in that the offgoing midnight to 8:00 a.m. shift did not inform the relieving shift that a normally closed containment isolation valve had been left open, nor had all required personnel signed the turnover checklist prior to oncoming personnel assuming shift duties.

This is a Severity Level IV Violation (Supplement I).

Response:

We concur with the violation as stated.

As immediate corrective action, a memorandum was issued November 16, 1982 by the Manager-Plant Operations to all operating shifts directing them to perform all shift turnovers in strict accordance with Procedure 106, "Conduct of Operations". In addition, the shifts were directed to specifically walk down the control panels with their respective reliefs and review the Shift Turnover Check-Off item by item. The Control Room Log Book was also required to be reviewed and signed prior to assuming shift duties. Completeness of logs and accuracy of entries made were also stressed in the memorandum.

To prevent recurrence, revisions to the Shift Turnover sections of Procedure 106, "Conduct of Operations" and Procedure 106.4, "Conduct of Operations, Radwaste and Augmented Off-Gas Facility", have been submitted for review and approval. The revised procedures reflect the guidelines presented in INPO's Good Practice Procedure OP-201, "Shift Relief and Turnover". The revisions made to the procedures and associated "Control Room Turnover Checklist" give more specific direction as to what should be covered in shift turnover and how it should be accomplished. These revisions are expected to be issued by March 31, 1983.

Furthermore, Operations Management conduct periodic observations of shift turnovers in the Control Room on a random basis.

As a result of the immediate corrective action, full compliance has been achieved.

Violation B:

Technical Specification 6.8.1 requires that written procedures be established, implemented and maintained that meet or exceed the requirements of Appendix "A" of NRC Regulatory Guide 1.33-1972.

Regulatory Guide 1.33-1972 requires that appropriate procedures for the Rod Worth Minimizer be prepared for reactor startup, shutdown, and changing modes of operation.

Contrary to the above, as of December 14, 1982, appropriate procedures were not established and implemented for the Rod Worth Minimizer in that no verification of the Rod Withdrawal Sequence entered in the Rod Worth Minimizer (RWM) was required prior to reactor startup. The failure to have an appropriate procedure contributed to conducting a Reactor Startup on December 14, 1982 with the wrong rod withdrawal sequence entered in the RWM.

This is a Severity Level IV Violation (Supplement I).

Response:

We concur with the violation as stated.

As cited in the Notice of Violation, a reactor startup was conducted on December 14, 1982 with an incorrect Rod Worth Minimizer (RWM) sequence input to the RWM. Investigation of this event disclosed that an incorrect RWM sequence tape was inserted during an extensive preventative maintenance testing program performed on the RWM during October and November 1982.

During the December 14, 1982 reactor startup, an "Out-of-Sequence" alarm was initiated by the RWM indicating that a control rod selected for withdrawal, as determined by the then-current and approved rod withdrawal sequence, was not the same rod programmed into the RWM. Control room operators immediately terminated the startup and contacted the Manager - Core Engineering and Manager - Plant Operations. The rod withdrawal sequence was reviewed and verified to be correct. Since the RWM would not allow withdrawal according to the correct sequence the RWM was bypassed, as permitted by the Technical Specifications. The sequence programmed into the RWM was reviewed and found to be incorrect.

It should be noted that the first eight (8) rod groups (68 control rods) programmed into the RWM were identical to those indicated on the correct rod withdrawal sequence. No incorrect rods were withdrawn. The RWM performed its function by initiating an alarm when the correct withdrawal sequence became incompatible with the sequence programmed into the RWM. The discrepancy was quickly discovered by control room personnel and corrective action was immediately taken.

In order to prevent recurrence of this event, Procedure 1001.5 "Rod Worth Minimizer" will be revised to provide additional guidance and strict control of the preparation, programming and subsequent storage of the RWM sequence tape. RWM program verification will be required just prior to plant startups. In addition, all outdated RWM sequence tapes have been destroyed to ensure that an incorrect tape cannot be programmed into the RWM. Storage and control of the RWM sequence tape will be the responsibility of the Core Engineering group.

Full compliance will be achieved with the review, approval and issuance of the procedure revision, which is expected by March 30, 1983.