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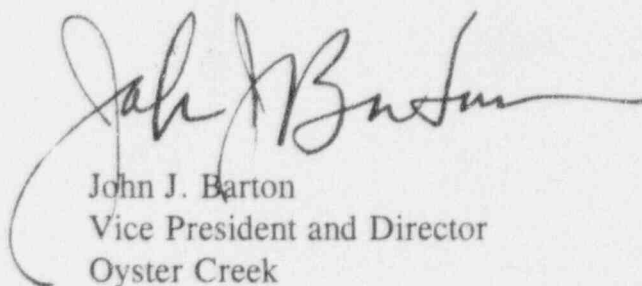
Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Inspection Report 50-219/94-14
Reply to Notices of Violation

By letter dated September 28, 1994, the USNRC docketed two Notices of Violation first identified as potential Notices of Violation in Inspection Report 50-219/94-14. Attachment I to this letter contains the reply to those Notices of Violation, as required by 10 CFR 2.201.

If any additional information or assistance is required, please contact Mr. John Rogers of my staff at 609.971.4893.



John J. Barton
Vice President and Director
Oyster Creek

JJB/JJR
Attachment

cc: Oyster Creek NRC Project Manager
Administrator, Region I
Senior Resident Inspector

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ATTACHMENT I

Violation A:

"Technical Specification 3.2.B.4 (Control Rod System) states that control rods which cannot be moved with control rod drive pressure shall be considered inoperable. Inoperable control rods shall be valved out of service in such positions that Specification 3.2.A (Core Reactivity) is met.

Technical Specification 3.2.A states that the core reactivity shall be limited such that the core could be made subcritical at any time during the operating cycle, with the strongest operable control rod fully withdrawn and all other operable rods fully inserted.

Contrary to the above, on July 26, 1994, the Group Shift Supervisor authorized a maintenance activity for hydraulic control unit No. 06-19, which was subsequently valved out of service, rendering its associated control rod inoperable at the fully withdrawn position such that the control rod could not be moved with control rod drive pressure. With the strongest control rod likewise fully withdrawn and all other operable rods fully inserted, the core reactivity was such that the core could not be made subcritical under all conditions, as determined by analysis."

Violation B:

"Technical Specification 6.8 (Procedures) states that written procedures shall be established, implemented, and maintained that meet or exceed the requirements of NRC Regulatory Guide 1.33, "Quality Assurance Program Requirements (Operation)", including procedures for startup, operation, and shutdown of safety related BWR systems.

Oyster Creek Plant System Procedure 302.1, "Control Rod Drive Hydraulic System", Prerequisite No. 8.2.2 (for hydraulic control unit isolation), states that "The control rod is latched in the "00" position (fully inserted). Otherwise, permission from the Core Engineering Manager shall be obtained to valve out Control Rod in any other position and meet the shutdown margin requirements of Technical Specification 3.2.A."

Contrary to the above, on July 26, 1994, while using procedure no. 302.1 to valve the control unit for control rod no. 06-19 out of service, the lead control room operator failed to either latch the control rod in position "00" or obtain the permission from the Core Engineering Manager. A subsequent review of the existing configuration (control rod no. 06-19 fully withdrawn), analytically determined that the shutdown margin requirements of Technical Specification 3.2.A were not met."

GPUN Reply to Violations A and B:

GPUN concurs with the violation as written.

Reason for the Violation

The cause of the violation was personnel error by the Group Shift Supervisor (GSS) in that he failed to verify the shutdown margin requirements prior to directing the isolation of the hydraulic control unit (HCU). Two contributing causes were identified: 1) the Lead Control Room Operator misinterpreted Technical Specification 3.2.A; and 2) there was poor communication between the GSS and the other crew members.

Corrective Actions Taken and the Results Achieved

Immediate corrective action was taken to unisolate the HCU and return it to full operability. Control rod 06-19 was then driven to the fully inserted position.

Corrective Steps Taken to Avoid Further Violations

The senior station manager and senior department management met with all of the operating crews to stress individual and team responsibilities with respect to communications and the need for a questioning attitude. Additionally, the computerized tagout system was revised to print out a caution statement relating to shutdown margin requirements on HCU tagouts. Finally, additional operator training has been scheduled during the licensed operator requalification training program to discuss shutdown margin and its bases. This training is scheduled to be completed during the first full quarter of training following the current refueling outage.

Date When Full Compliance was Achieved

Full compliance was achieved when the inappropriately isolated HCU was returned to service on July 26, 1994.