



GPU Nuclear Corporation
Post Office Box 388
Route 9 South
Forked River, New Jersey 08731-0388
609 971-4000
Writer's Direct Dial Number:

April 11, 1991
C321-91-3001

Thomas E. Murley, Director
Office of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Attn.: Document Control Desk
Washington, DC 20555

References: Information Notice 91-22, "Four Plant Outage Events
Involving Loss of AC Power or Coolant Spills"
Letter; Murley (NRC) to Barton (GPUN) dated March 25, 1991

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Management Review of Information Notice 91-22

On March 19, 1991, the USNRC issued Information Notice (IN) 91-22, referenced above. Included in IN 91-22 was a discussion of the degradation in electrical system redundancy which occurred at the Oyster Creek Nuclear Generating Station on March 9, 1991. Although the discussion in IN 91-22 was accurate, it was a preliminary summary of the event, and therefore incomplete. This letter is being written for two purposes: 1) to update the information presented by the NRC in IN 91-22; and 2) to provide a GPU Nuclear management response to the USNRC letter referenced above.

The event at Oyster Creek was initiated when a Diesel Generator was declared inoperable after failing a routine surveillance test. Immediate corrective actions were taken to comply with existing Technical Specifications. Additionally, access to areas which could threaten the remaining normal power path was restricted, and the electric utility System Dispatcher was contacted to ensure maximum reliability for the remaining source of power. Plant conditions were stabilized and maintained while additional risk minimization actions were taken.

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Portable diesel generators of sufficient capacity were located and brought to the site. Existing procedures for alternate sources of power were reviewed and evaluated. It was determined that several alternate sources of electric power could be made available in a relatively short period of time.

Concurrently, alternate means to provide both water inventory and core cooling without electric power were identified and prioritized. Aggressive recovery action to restore the inoperable Diesel Generator worked around the clock.

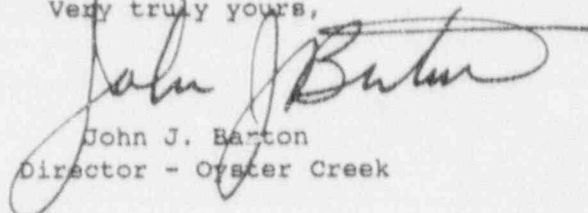
After the restoration of the failed Diesel Generator, an Independent Safety Review of the event was initiated to determine if additional mitigating factors could have been implemented or pre-staged. Additionally, the Director-Oyster Creek established an Outage Risk Reduction Team to assess the ongoing and planned conduct of the refueling outage and determine if appropriate limitations and controls were in place to avoid unnecessary increases in risk. The report from the Independent Safety Review Group was completed on March 25, 1991. The Outage Risk Reduction Team identified four "vital functions" (core inventory, core cooling, containment, and electric power) which need to be considered whenever a change to system availability is planned. These two efforts are presently under management review to determine if additional improvements in risk minimization can be implemented.

Separate from the internal GPUN efforts, the NRC sent an Augmented Inspection Team (AIT) to collect information and evaluate this event. The AIT proposed a few areas where administrative improvements could be made, and suggested that outage planning in general should consider risk in scheduling system outages.

Finally, GPUN has reviewed IN 91-22 and has determined that the actions taken at Oyster Creek to date encompass and exceed those suggested in the Information Notice.

If any additional information would be of assistance, please call Mr. John Rogers at 609-971-4893.

Very truly yours,


John J. Barton
Director - Oyster Creek

JJB/JJR
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cc: Document Control Desk, USNRC
Administrator, Region I
Senior Resident Inspector
Oyster Creek NRC Project Manager