PSE&G

Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, NJ 08038 609 339-4800

Corbin A. McNeill Jr. Vice President — Nuclear

April 29, 1985

Regional Administrator, Region 1
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Attention: Samuel J. Collins, Chief
Projects Branch No. 2
Division of Reactor Projects

Gentlemen:

COMBINED INSPECTION 50-272/85-03 AND 50-311/85-03
SALEM GENERATING STATION
UNIT NOS. 1 AND 2
DOCKET NOS. 50-272 AND 50-311

Public Service Electric and Gas Company is in receipt of your letter dated March 28, 1985, which transmitted a Notice of Violation of a limiting condition for operation resulting from failure to follow procedures for conducting containment pressure relief operations.

Pursuant to the provisions of 10 CFR 2.201, our response to the Notice of Violation is provided in Attachment 1.

Sincerely,

Attachment

C Mr. Donald C. Fischer
Licensing Project Manager

Mr. Thomas J. Kenny
Senior Resident Inspector

IE01/1

ATTACHMENT 1

10 CFR PART 2.201 INFORMATION
PUBLIC SERVICE ELECTRIC AND GAS COMPANY
SALEM GENERATING STATION
RESPONSE TO NOTICE OF VIOLATION

Your letter of March 28, 1985, identified a violation of technical specifications 3.3.3.1 and 3.9.9 involving failure to follow an operating procedure for conducting containment pressure relief operations.

On February 13, 1985, the containment iodine channel, 1R12B, was made inoperable as a result of testing. The plant vent iodine monitor isolation channel setpoint was not reduced, resulting in a loss of automatic purge and pressure/vacuum relief isolation capability. During this period, each of the purge and pressure/vacuum relief penetrations providing direct access from the containment atmosphere to the outside atmosphere were not kept closed in that two containment venting operations were conducted.

1. PSE&G DOES NOT DISPUTE THIS VIOLATION

2. THE ROOT CAUSE OF THIS VIOLATION WAS PERSONNEL ERROR

   Specifically, the operator failed to follow the procedure. Contributing to the event was the lack of adequate supervision by the shift supervisor concerning the inoperability of the 1R12B monitor and its effect on plant operations.

3. IMMEDIATE CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

   On February 14, the day after the incident, the shift supervisor found that the procedure had been violated. The violation was immediately reported to the NRC Resident Inspector and subsequently a Licensee Event Report was submitted. The operator was disciplined and the shift supervisor and senior shift supervisor were reprimanded. The operators were informed of the incident via the Operations Department Newsletter.

4. LONG-TERM CORRECTIVE ACTION THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

   A discussion of this violation will be included in the next scheduled training program for individual station departments.

A lamacoid label has been affixed to the console on each unit next to the pressure/vacuum relief valve pushbuttons to caution the operators that when the containment monitor is out of service and the plant vent monitor is functioning in this capacity, the setpoints must be reduced to provide automatic purge and pressure/vacuum relief isolation capability.

A review of this and another incident which occurred on May 28, 1984 has been performed. The conclusion is that even though the same Limiting Condition for Operation (LCO) was violated, the root causes were not the same. The first violation was caused by the inappropriate use of the procedure for implementing on-the-spot changes. The second violation resulted from failure to follow the operating procedure for conducting containment pressure relief operations. A review of the procedure was performed and no procedural inadequacies were found. A review of the Corrective Action for the first violation has concluded that the steps taken were adequate.

Notwithstanding the above conclusions, we share the NRC's concern regarding the two violations of the same LCO. The occurrence of repeat violations will receive particular management attention during the next training cycle to assure that similar incidents do not recur. Additionally, there have been other recent station occurrences indicating a lack of procedural compliance. A plan of action to address this issue is being formulated.