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November 24, 1997
6730-97-2030

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Reply to a Notice of Violation
Inspection Reports: 96-09 and 96-11

In accordance with 10 CFR 2.201, Attachment 1 provides GPU Nuclear's response to the violations identified in the subject inspection reports. During discussions held with Region I NRC staff on January 6, 1997, it was agreed that the due date for this response would be extended to January 24, 1997.

If you should have any questions or require further information, please contact Brenda DeMerchant, Oyster Creek Regulatory Affairs Engineer, at 609-971-4642.

Very truly yours,

Michael B. Roche
Vice President and Director
Oyster Creek

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cc: Administrator, Region I
NRC Project Manager
NRC Sr. Resident Inspector

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Response to IR 96-009 Notice of Violations

Violation 1

Technical Specification 6.8.1, states, written procedures shall be established, implemented, and maintained that meet or exceed the requirements of NRC Regulatory Guide 1.33.

NRC Regulatory Guide 1.33, Appendix A, Paragraphs 4 and 1, state, in part, that procedures should be prepared as appropriate, for Startup, Operation, and Shutdown of Safety-Related BWR Systems, including the Control Rod Drive System, and Administrative Procedures including Equipment Control (e.g., Locking and Tagging).

Procedure 302.1, Control Rod Drive Hydraulic System, Revision 57, Section 10.0, Alternate CRD Cooling and Drive Water Supply, Paragraph 10.3.5, Steps 10.3.5.1, and 10.3.5.2, directed the operator to Open valves V-11-49 and V-11-63 (to provide a water source for the Jockey pump).

Contrary to the above, on September 17, 1996, the operator failed to follow the procedure and opened valves V-11-44 and V-11-63. V-11-63 was subsequently closed to isolate a hose leak and V-11-44 was left open. This valving error caused the cross connection of the fire water system and the condensate transfer system and resulted in an unplanned and unmonitored release of 133,000 gallons of slightly radioactive water when the correct valve, V-11-49, was opened to place the alternate CRD system in service.

Procedure 108.5, Control of Locked Valves and Breakers, Revision 1, Section 4.1.1, the criteria for locking valves shall be: Step 4.1.1.7 states, "Valves that are required to be positioned to prevent contamination of other systems or areas (radiological, chemical, liquid waste, etc.)."

Contrary to the above, valve V-11-44, a valve that prevents cross contamination of the fire system from the condensate transfer system, was not locked. This is a second example of failure to follow procedure which contributed to the unplanned and unmonitored release of 133,000 gallons of slightly radioactive water.

This is a severity Level IV violation. (Supplement I)

Response:

GPUN concurs with the violation as written.

Reason for the Violation:

The root cause of the Procedure 302.1 violation was personnel error. The operator did not have the procedure in hand when placing the jockey pump in service and did not properly self-check his actions to ensure that the correct valve was manipulated.

The root cause of the Procedure 108.5 violation was procedural inadequacy in that relevant information regarding the increased potential for cross contamination occurring while in the temporary modification configuration was not addressed in the safety review for Procedure 302.1.

The Corrective Steps Taken and the Results Achieved:

On September 18, at 0830, following the discovery that an overboard discharge had occurred, V-11-44 was locked closed and the jockey pump was relocated to a connection where there was no potential for an overboard discharge or cross-contamination to occur. Subsequent to this incident, operations personnel conducted an extensive investigation documented in a detailed critique.

Among the completed corrective actions as a result of this incident are the following:

A walkdown was performed to ensure that proper controls are in place at other system interfaces where the potential for discharge or cross-contamination exists. As a result, one other valve was locked and warning signs were posted to indicate that a potential for cross-contamination exists.

Valve V-11-44 was renumbered V-9-2099, a Fire Protection System valve number.

Shortly after the incident, briefings were conducted with all licensed and non-licensed operators which included the following topics:

- The need to maintain awareness of plant status above all other priorities was re-emphasized;
- Shift briefings to review plant status at the beginning of each shift were instituted;
- The need to employ self-checking was re-emphasized;
- "Procedure in-hand" requirements were re-emphasized;
- The need to understand changing plant conditions and aggressively identify unknown conditions was re-emphasized.

A safety evaluation to address continued operation of the Fire Protection System as a contaminated system was completed.

The Corrective Steps that will be Taken to Avoid Further Violations:

Procedural guidance will be developed and training provided to assist operations personnel in identifying tank inventories and expected changes during refueling outages when tank inventories are subject to wide fluctuations;

The practice of allowing temporary modifications to be added to procedures without the Technical Evaluation form from Procedure 108.8 will be re-evaluated to ensure that controls are adequate.

A standing order or procedural controls will be developed to include a listing of potential cross-contamination and overboard discharge points, instructions and restrictions, as needed, to ensure proper operation of the effected components, and instructions for response to a spill or discharge.

These actions will be completed by the end of the first quarter, 1997.

Full compliance was achieved on September 18, 1996, at 0830 when valve V-11-44 was closed and locked.

Violation 2

Code of Federal Regulations, Title 10, Energy, Part 50.59, Changes, Tests and Experiments, Section (a)(1), states that the holder of a license (i) may make changes to the facility as described in the safety analysis report, and (ii) make changes in procedures as described in the safety analysis report without prior Commission approval, unless the proposed change involves a change in the Technical Specifications or involves an unreviewed safety question. Section (b)(1) states that the licensee shall maintain records of changes ... made pursuant to this section. Those records must include a written safety evaluation which provides the basis for the determination that the change does not involve an unreviewed safety question.

Contrary to the above, a permanent change (September, 1994) was made to Procedure 302.1, Control Rod Drive Hydraulic System and to the facility, as described in the safety analysis report (SAR) involving use of a CRD "jockey pump" to provide a different means of providing a CRD cooling and drive water supply than was described in the SAR without a written safety evaluation to determine if an unreviewed safety question existed. A second minor example of failure to perform a written safety evaluation as required by 10 CFR 50.59 occurred in July, 1995, when an annunciator alarm function described in the SAR was disabled.

This is a severity Level IV violation (Supplement 1)

Subsequent to receiving the above violation, the following similar violation was received in Inspection Report 96-11:

Title 10, Code of Federal Regulations, Part 50.59, "Changes, Tests, and Experiments," (10 CFR 50.59), Section (a)(1) requires, in part, that licensees may make changes in procedures as described in the safety analysis report without prior NRC approval, unless the proposed change involves an unreviewed safety question. Section (b)(2) of 10 CFR 50.59 requires, in part, that licensee's records of changes in procedures must include a written safety evaluation which provides the bases for the determination that the change does not involve an unreviewed safety question.

Contrary to the above, a written safety evaluation was not performed to provide the bases for the determination that a change to station procedure 336.3, "Generator Hydrogen Gas System," did not involve an unreviewed safety question. Specifically, on February 23, 1994, procedure 336.3 was changed to add instruction to manually adjust cooling flow for the generator hydrogen coolers rather than using the automatic temperature control valve as described in the safety analysis report, however, a written safety evaluation was not completed.

This is a severity level IV violation.

Response:

GPU Nuclear concurs with the violations with regard to incomplete safety evaluations. The practice of using a jockey pump is controlled as a temporary modification and, therefore, does not constitute a permanent change to the facility.

Reason for the Violations:

The violations occurred due to personnel error in not accurately addressing the questions of the GPU Nuclear 10 CFR 50.59 Safety Determination form used at that time.

The Corrective Steps Taken and Results Achieved

In all instances where inaccurate safety determinations have been performed the appropriate system engineers have been assigned action to review and revise or prepare, if necessary, a safety evaluation which accurately reflects the Safety Analysis Report (SAR) or propose a change to the FSAR, if required.

The Corrective Steps that will be taken to Avoid Further Violations:

The Safety Review training program will be enhanced emphasizing the need to accurately answer the safety determination questions and will include discussions of the tools available to assist in these reviews (e.g., computer databases, etc.). These violations will be used as examples to emphasize the importance of performing thorough reviews and preparing complete documentation, as well as examples of where SAR revisions are warranted.

A "Safety Review Newsletter" will be prepared and issued to all qualified safety reviewers clarifying and reinforcing expectations as well as citing these examples of improper safety evaluations.

Full compliance will be achieved when the appropriate system engineer has reviewed the incorrect safety determination and revises or updates/corrects it. Cited safety evaluations involving recurring outage related modifications (jockey pump) will be completed six months prior to the next outage which is currently scheduled for October, 1998. Safety evaluations involving the remaining inaccuracies will be reviewed and revised by the end of the first quarter, 1997. Regarding Station Procedure 336.3, "Generator Hydrogen Gas System," the continued operation

of the plant while the safety evaluation is being written has been determined to be acceptable as the Turbine Building Closed Cooling Water System is not Nuclear Safety Related and cools no safety related components.