

Nuclear

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February 26, 1988

Thomas T. Martin, Director
Division of Radiation Safety and Safeguards
Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

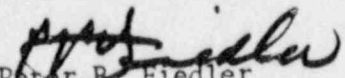
Dear Mr. Martin:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Inspection 87-41 - Response to Violation

As directed by the subject Inspection Report dated January 28, 1988, Attachment I provides our response to the two (2) violations identified. GPUN concurs with the findings stated in the Notice of Violation.

Should you require any further information, please contact Michael Heller, Oyster Creek Licensing Engineer at (609) 971-4680.

Very truly yours,


Peter B. Fiedler
Vice President & Director
Oyster Creek

jlr (2077j)
Attachment

cc: Mr. William T. Russell, Administrator
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NRC Resident Inspector
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Attachment I

Violation:

Technical Specification 6.8.1 requires that written procedures shall be established, implemented, and maintained.

- (1) Station Procedure 108 Equipment Control, step 5.2.17 states, The RED/WHITE is a mechanical tag and is to be used on mechanical equipment such as valves, mechanical controls, etc., where the operation of such equipment would create a condition unsafe to life or property. No equipment bearing a RED/WHITE tag shall be operated for any reason whatever.

Contrary to the above, during a plant walkdown performed on November 28, 1987, two containment spray pump suction gauge isolation valves which were tagged shut had their RED/WHITE tags removed and were found to be open.

Response:

GPUN concurs with the violation as stated.

The red/white tags had been temporarily removed and the isolation valves opened so that the pump suction pressure could be obtained as part of a scheduled surveillance. This was done in accordance with Procedure No. 108, "Equipment Control" whereby an operator can remove tags and become the controlling mechanism for the outage as long as he remains continuously present at the tagged components until the tags are rehung or ordered permanently removed. However, the surveillance was interrupted while in progress and the operator failed to rehang the tags when he left the area. Upon identification of this deficiency, immediate action was taken to close the suction pressure gauge isolation valves and rehang the red/white tags.

Full compliance was achieved as of November 30, 1987.

The gauges had been isolated and tagged out of service because the seismic mounting of the gauges was under review. It was discovered as a result of this event that an engineering evaluation had been previously completed but not conveyed to the Operations Department and that the mounting satisfied all seismic criteria. Therefore, the tagout was subsequently cleared and the valves repositioned in accordance with Station Procedure No. 310, "Containment Spray System Operation".

Violation:

Technical Specification 6.8.1 requires that written procedures shall be established, implemented, and maintained.

- (2) Station Procedure 310, Containment Spray System Operation, provides detailed instructions for the operation of the containment spray system. This includes a valve line up of the system in accordance with valve check off list figure 310-1. This valve check off list prescribes heat exchanger 1-1 and 1-2 pressure indication gauge isolation valves V-3-506, 507, 513 and 514 be open.

Contrary to the above, during a plant walkdown performed on November 28, 1987, these valves were found to be shut.

Response:

GPUN concurs with the violation as stated.

The mispositioning of these valves occurred as a result of a surveillance test. The heat exchanger 1-1 and 1-2 pressure indication gauge isolation valves V-3-506, 507, 513 and 514 are located on top of their respective heat exchangers in close proximity to the differential pressure gauge isolation valves V-3-435 and 436. The operator believed that he was to isolate all the gauges on top of the heat exchangers at the completion of the surveillance. However, only the differential pressure gauges were to be isolated by the surveillance procedure as they were installed as are temporary variations which are used for performance monitoring. The operator failed to consult the surveillance procedure and inadvertently shut the pressure gauge isolation valves along with the differential pressure gauge isolation valves. Immediate corrective action was taken and a valve lineup was performed on these instrument lines in accordance with valve check off list figure 310-1. These valves were repositioned and independently verified.

Full compliance was achieved as of November 30, 1987.

Subsequent to this event, a plant modification was completed and differential pressure gauges were permanently installed. The temporary variation was removed and the valve lineup checklist was changed to incorporate this modification.

Corrective Actions

The following corrective actions will be taken to prevent future recurrence of these items:

- (1) The Operations Department incident critique report for this event will be incorporated into the Required Reading Program for all Operations Department personnel.

Projected Completion Date: 3/31/88

- (2) Operations Department Management shall review this event with all Operations Department personnel and stress the importance of procedural compliance, attention to detail, and proper communications.

Projected Completion Date: 3/31/88

- (3) The Operations Department shall evaluate the current practice of using operators as a human tagout boundary and if deemed inappropriate, revise Procedure No. 108, "Equipment Control" to eliminate this practice.

Projected Completion Date: 6/30/88