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V. S. BOYER
SR. VICE PRESIDENT
NUCLEAR POWER

April 27, 1983

Docket Nos. 50-277
50-278

Director
Office of Inspection and Enforcement
US Nuclear Regulatory Commission
Washington, DC 20555

Dear Sir:

By letter dated March 29, 1983 (R. C. Haynes, NRC to V. S. Boyer, PECO.) Philadelphia Electric received a Notice of Violation and Imposition of Civil Penalties E. A. No. 83-7.

Philadelphia Electric agrees with the description of the events contained in your letter. We believe that the events cited in each instance are the result of individual personnel error and do not reflect programmatic deficiencies. The safe nuclear operating record at Peach Bottom reflects Philadelphia Electric Company's dedication and commitment to excellence in operation without the need for imposition of civil penalties to ensure that corrective actions are fully implemented. The thrust of the charge is against the program. Isolated actions of individuals should not be the basis for directing civil penalties at a program, particularly when the program itself disclosed the conditions and instituted action for prompt corrections. Attachments I and II discuss the corrective measures that were instituted promptly in response to the events, the most significant of which we called to your attention. We appreciate your recognition of this principle as applied in one instance with a reduction of the proposed penalty by 50% on this basis. However, we believe that your acceptance of this principle together with the prompt corrective action should mitigate the penalties entirely. Nevertheless, as evidence of our good faith,

we have enclosed our check for $140,000.00, which we hope you will remit if you agree with our position.

Your letter of March 29, 1983, indicates that the Enforcement Policy permits consideration of mitigating circumstances. Prompt action taken by Philadelphia Electric Company in shutting down the plant and performing short term corrective actions in response to Violation I.C resulted in a 50% reduction of the proposed civil penalties for this event. In response to the significant number of personnel errors and procedural violations in the health physics area in mid 1982, prompt action was taken by developing a Health Physics and Radwaste Action Plan. This Plan provided both detailed response to each of the identified deficiencies as well as an overall management response for program improvements. The Health Physics and Radwaste Action Plan was provided to the NRC Inspector on a periodic basis in order to show progress in meeting the goals of this Plan. Your followup inspection performed in the radiation protection area in December 14-17, 1982, documents the improvements made by Philadelphia Electric Company in the area of radiation protection. Based on Philadelphia Electric Company's extensive program and significant improvements made within a six month period, we believe that the civil penalty for Violation II should have been omitted or reduced.

A broad spectrum of corrective actions were undertaken in response to the valving errors identified in mid-1982 and discussed with senior Region I management on January 18, 1983. The details of these actions are contained in Attachment I. Each corrective action statement identifies the applicable violation. In the radiation protection area, a Health Physics (HP) and Radwaste Action Plan was formulated. This action plan included the investigation and resolution of some sixty-six items. Attachment II to this letter identifies those items applicable to the radiation protection area and the status of that item as of April 1, 1983. The HP and Radwaste Action Plan has been updated and provided to the Resident Inspector at Peach Bottom on a routine basis. This letter restates each of the violations and provides specific details.

I. RESTATEMENT OF VIOLATIONS RELATED TO REACTOR OPERATIONS

Technical Specifications 6.8.1 and 6.8.2 require establishment, implementation, maintenance, and PORC (Plant Operation Review Committee) review of written procedures that meet Appendix A of Regulatory Guide 1.33. Appendix A of Regulatory Guide 1.33 identified significant

administrative and test procedures, and procedures for startup, operation, and shutdown of safety-related Boiling Water Reactor systems.

Restatement of Violation I.A.

A. Procedure RT 8.0.2, Revision 3, "Safety Instrument Valving Check-Off List," a procedure required to meet Appendix A of Regulatory Guide 1.33, requires that the equalizer valves for the main steam line flow and flow trip transmitters be closed for power operation. Procedure ST 9.1-2, Revision 25, " Surveillance Log," a similarly required procedure, requires that shift supervision perform daily comparison/consistency checks of instruments monitoring the same parameter.

Technical Specification 3.7.A requires primary containment integrity whenever the reactor is critical. Whenever primary containment integrity is required, Technical Specification 3.2.A and Table 3.2.A require a minimum of two operable instrument channels per trip system for instrumentation monitoring high flow in the main steam lines and also requires that if this condition cannot be met, the associated trip system shall be tripped or the main steam lines shall be isolated within eight hours.

Contrary to the above,

1. On June 25 and July 6, 1982, Procedure RT 8.0.2 was completed; however on July 3, 1982, with the Unit 2 reactor critical at 34% power, a flow transmitter and a high flow trip transmitter for the "D" main steam line each had open equalizing valves; and from July 6, 1982 until July 9, 1982, with the Unit 2 reactor critical between 34% and 90% power, a high flow trip transmitter for the "A" main steam line had an open equalizer valve, resulting in an inoperable trip channel. The associated trip system did not have a minimum of two operable channels, the associated trip system was not tripped, nor were the main steam lines isolated within eight hours.

2. From July 6, 1982 until July 8, 1982, adequate comparison/consistency checks of the "A" main steam line differential pressure transmitter readings were not performed by shift supervision in that the

readings for transmitter DPIS-116B, which had the open equalizer valve, were substantially lower than the readings from the other three differential pressure transmitters measuring the "A" main steam line differential pressure, and this inconsistency (16 psid on July 6, 1982; 23 psid on July 7, 1982; and 36 psid on July 8, 1982) was not recognized until July 9, 1982.

This is a Severity Level III Violation (Supplement I). Civil Penalty - $40,000.

Response to Violation I.A

The incident cited in this violation was reported to the NRC in Licensee Event Reports 2-82-15/1P-0 dated July 6, 1982, 2-82-16/1P-0 dated July 13, 1982, and 2-82-15/1T and 2-82-16/1T-0 dated July 16, 1982. As stated in the LER, this instrument is part of a one-out-of-two-twice logic system which will cause the isolation of the monitored main steam line upon the incidence of high steam flow (greater than 140% of normal full power steam flow). With the equalizer valve open, the instrument was inoperable. However, redundant instrumentation was available to provide the necessary trip signal.

Philadelphia Electric Company's investigation of Violation 1.A basically agrees with the analysis provided in your letter of March 29, 1983 which states:

Violation I.A involves improper positioning of main steam line differential pressure transmitter equalizer valves, inadequate verification of valve positions, and inadequate daily review of differential pressure readings by shift supervision. These inadequacies contributed to the violation of a technical specification limiting condition for operation (LCO), in that the plant operated without the required number of operable channels for a main steam line isolation trip system. On June 25, 1983, and July 6, 1982, equalizer valve positions were checked for verification purposes without recognition that the valves were improperly positioned. Also, although sufficient information existed in the daily surveillance log on July 6, 1982, July 7, 1982 and July 8, 1982 to indicate the equalizer valve was mispositioned for one of the "A" main steam line transmitters, this condition was not recognized until July 9, 1982. This log was signed on those dates by the Shift Supervisor, the Shift Technical Advisor, and a Test Engineer.

The primary cause of this violation was personnel error. The main steam line differential pressure transmitter equalizer valves were opened during the hydrostatic test performed on the Unit 2 reactor near the end of the refueling outage. In preparing the plant for startup, the instrument rack valves were to be returned to the normal position by two instrument technicians performing a valve check-off list. Because several of these equalizer valves were hard on the backseat, the instrument technicians were mislead. The normal manner of checking valves in the closed position is to attempt to close the valve and check for no valve motion. In this case, the instrument technician attempting to close the valve could not move the valve because it was jammed on its backseat. He, therefore, assumed that the valve was closed. Following the identification of the first opened equalizer valve, two experienced engineers performed the instrument valve checkoff list and again failed to identify the second valve which was jammed on its backseat. The condition existed for three more days until an operator noticed the lower reading on the transmitter which had the open equalizer valve. Individuals who were assigned responsibility for reviewing the main steam line flow transmitter differential pressure on a daily basis failed to recognize the one low reading among the 16 readings being reported for these flow transmitters. Failure to recognize this discrepancy was caused by inadequate attention to detail by review personnel.

Corrective actions taken as result of this violation as well as steps taken to avoid further violations are provided in Attachment 1 to this report. Attachment 1 also provides the status of each of the corrective actions and their applicability to this particular violation.

Restatement of Violation I.B.

B. Test Procedure ST 12.6-2, Revision 3, "Primary Containment Drywell to Torus Bypass Area Test," reviewed by PORC, requires use of an installed differential pressure switch DPIS-3503A to obtain required readings. Administrative Procedure A-3, Revision 6, "Procedure for Temporary Changes to Approved Procedures," requires that shift supervision and a PORC member approve temporary procedure changes which do not change the intent of a procedure, and requires that PORC approve such changes within 14 days. This procedure also requires that PORC

approve procedure changes affecting the intent of the procedure prior to the change being implemented.

Technical Specification 3.7.A.2 requires primary containment integrity whenever the reactor is critical. The Technical Specification surveillance requirement specifies that primary containment intergrity is confirmed if the leakage rate does not exceed the equivalent of 0.5 percent of primary containment volume per 24 hours at 49.1 psig.

Technical Specification 3.7.A.3 requires two operable reactor building to suppression chamber vacuum breakers in each line whenever primary containment integrity is required, but permits operation up to seven days with one inoperable breaker provided primary containment integrity is not violated.

Contrary to the above, on September 29, 1981, the Primary Containment to Torus Bypass Area Test was performed on Unit 3 using a manometer instead of the required differential pressure switch DPIS-3503A, without a temporary change to Procedure ST 12.6-2 being established, reviewed, and approved. Furthermore, upon completion of the test, the manometer isolation valve was left open, resulting in the following degraded conditions between October 2, 1981 and May 27, 1982:

1. Primary containment integrity was not maintained while the reactor was critical in that the leakage rate was 0.65 percent of the primary containment volume per 24 hours;

2. Reactor Building to Suppression Chamber Vacuum Breaker "A" was inoperable.

This is a Severity Level III Violation (Supplement I). Civil Penalty - $40,000.

Response to Violation I.B.

This event was reported to the NRC in License Event Reports 3-82-08/1T-0 dated June 18, 1982, and 3-82-08/1P-0 dated May 28, 1982. This LER pointed out that the redundant vacuum breaker was available and that leakage at normal containment operating pressures (0.5 psig) was approximately 12 SCFH. This very low level leakage at normal operating pressure was extremely difficult to identify with existing instrumentation and therefore continued for an extended period of time.

Philadelphia Electric Company's investigation of Violation I.B. basically agrees with the analysis provided in your letter of March 29, 1983, which states:

> Violation I.B involved the failure to adhere to a Technical Specification LCO for primary containment integrity. The violation resulted from the use of a manometer, instead of the procedurally required differential pressure switch, to perform a drywell to torus bypass area test. A temporary procedure change was not obtained. The use of the manometer provided a containment leakage path which increased containment leakage above established limits and also defeated a pressure switch which resulted in one of the torus to reactor building vacuum breakers being inoperable.

The primary cause of this violation is personnel error. During the performance of the drywell to suppression pool bypass test at the end of the Unit 3 outage in 1981, the procedure required the measurement of the pressure within the torus. The installed instrument only reads negative pressure. However, during this test, the torus pressure was positive. The engineer performing this step in the procedure installed the manometer to obtain the required data in support of the test procedure; however, he failed to remove the manometer following the completion of the test. Because a temporary procedure change which would have included the positioning of valves for installation of this manometer was not processed, no second verification of the removal of the manometer was provided. Because the leakage through the manometer was very low during the period it was installed, the containment leakage was not readily identifiable.

In response to this event, Surveillance Test ST9.16 "Containment Gross Leak Rate Detection" has been revised. This procedure will minimize this type of failure and it should serve to preclude a similar situation recurring where containment leakage is excessive for an extended time period.

Corrective actions taken as result of this violation as well as steps taken to avoid further violations are provided in Attachment 1 to this report. Attachment 1 also provides the status of each of the corrective actions and their applicability to this particular violation.

Restatement of Violation I.C.

C. Administrative Procedure A-8, Revision 4, January 22, 1980, "Procedure for Control of Locked Valves," requires that locked valve repositioning be entered in the locked valve log and that such valves be restored to their normal position.

Technical Specification 3.7.A.2 requires containment integrity whenever the reactor is critical. Section 1.0 of the Technical Specifications defines containment integrity and specifies as one of its conditions that all non-automatic containment isolation valves on lines connected to containment be closed, if not required to be open during accident conditions.

Contrary to the above, during a Unit 2 maintenance outage from August 6-12, 1982, the Unit 2 service air inboard and outboard, non-automatic containment isolation valves were repositioned (unlocked and opened for pneumatic tool use in the drywell) without being entered in the locked valve log. These valves were not positioned to their normal closed position and locked until Spetember 10, 1982, resulting in primary containment integrity not being maintained while the reactor was critical between August 12, 1982 and September 10, 1982.

This is a Severity Level III Violation (Supplement I). Civil Penalty - $20,000.

Response to Violation I.C.

This event, reported to the NRC under Licensee Event Report 2-82-27/1T-0, resulted in the declaration of an Unusual Event and an immediate Reactor Shutdown for the purpose of entering containment to check and close the inboard isolation valve.

Philadelphia Electric Company's review of Violation I.C. basically agrees with the analysis provided in your letter of March 29, 1983, which states:

Violation I.C involved the failure to adhere to a technical specification LCO for primary containment integrity in that the inboard and outboard isolation valves for service air were not closed after the valves had been opened to obtain service air inside containment for maintenance purposes

during the August 6-12, 1982 maintenance outage. When the valves were originally opened to obtain service air, the repositioning was not entered into the "Locked Valve Log" as required. The failure to complete the log defeated an administrative control, namely, review of the log prior to startup to assure valves had been correctly repositioned. This resulted in a degraded condition since a containment leakage flow path could exist if, during accident conditions, multiple failures of the non-seismic portions of the service air system occurred. As discussed,in response to I.A.1 and 2 above, this event is the result of failure to follow procedures, a personnel error.

The primary cause of this violation was personnel error. Failure to follow the administrative requirements for logging locked valve operations in their abnormal position prevented appropriate review and correction of this valve mispositioning prior to startup. To a lesser extent, personnel awareness of the significance of locked valves and the identification of the importance of these valves also contributed to this event.

Corrective actions taken as result of this violation as well as steps taken to avoid further violations are provided in Attachment 1 to this report. Attachment 1 also provides the status of each of the corrective actions and their applicability to this particular violation.

II. RESTATEMENT OF VIOLATIONS RELATED TO RADIATION PROTECTION

Technical Specification 6.13.1.b requires that the keys to high radiation areas with dose rates greater than 1,000 mrem/hr be maintained under the administrative control of the shift superintendent or shift supervisor to prevent unauthorized entry into such areas.

Technical Specification 6.13.1.a requires that each individual or group of individuals who enters a high radiation area shall either; (1) have a radiatin monitoring device which continuously indicates the radiation dose rate in that area; (2) have a radiation monitoring device which continuously integrates the radiation dose rate in that area and alarms when a preset integrated dose is received; or (3) be accompanied by an individual qualified in radiation protection procedures who is equipped with a radiation dose monitoring device. Technical Specification 6.11 (Radiation Protection Program) requires that procedures for personnel

radiation protection consistent with the requirements of 10 CFR 20 be approved, maintained, and adhered to for all operations involving personnel radiation exposure. Contrary to the above, during April, May and June 1982, the licensee failed to comply with all or part of the above requirements as indicated below:

a. Notwithstanding Technical Specification 6.13.1.b, in June 1982, keys to the Unit 3 Turbine Building Moisture Separator Sparger Area, a high radiation area with dose rates greater than 1,000 mrem/hr. were not under the administrative control of the shift superintendent or the shift supervisor, in that keys were issued to and placed under the administrative control of auxiliary operators and the Health Physics Engineer.

b. Notwithstanding Technical Specification 6.13.1.a, on June 6, 1982, an auxiliary operator used a key to make an unauthorized entry into the Unit 3 Turbine Buiding Moisture Separator Sparger Area, and the individual did not have either a continuously indicating dose rate monitoring device or a continuously integrating dose rate monitoring device, nor was the individual accompanied by another individual qualified in radiation protection. Additionally, the auxiliary operator did not read, understand, or sign the RWP.

c. Procedure HPO/CO-17D, Compacting and Storage of Radioactive Trash in Drums, Revision 5, dated March 5, 1981, requires that all waste be free of excess moisture or free standing liquids. However, on June 4, 1982, a compacted and sealed metal low specific activity (LSA) waste container, awaiting shipment, was leaking oil and had contained at least two quarts of oil.

d. Procedure HPO-CO/4 (SIC), Radiation Work Permits (RWPs), Revision 1, dated December 18, 1981, establishes the method by which radiation work permits are obtained, used, and terminated. Section I (1) of procedure HPO-CO/4 requires an RWP for all entries into high radiation areas greater than 100 mrem/hr. However, on June 2, 1982, individuals entered the waste storage area outside the waste compactor room, a high radiation area with radiation levels 160-200 mrem/hr and the individuals did not have an RWP.

e. Section I (2)(d) of procedure HPO-CO/4 (SIC) requires an RWP for activities involving exposure to contamination or high levels of radiation. However, on April 23, 1982, an individual used a wire brush inside a

contaminated valve body in the drywell and caused airborne activity, and such work was not authorized by the RWP (2-01-01379A). Additionally, other individuals in the area were not wearing respiratory equipment as required when airborne activity is present.

f. Section VI of procedure HPO-CO/4 (SIC), Radiation Work Permits (RWP), Revision 17, December 18, 1981, requires that personnel read, sign, and be familiar with the data and instructions on the RWP, and comply with all conditions and prescriptions of the RWP. However,

1. On June 2, 1982, an individual entered the Recombiner 3B Compressor Room and started a compressor resulting in airborne radiation, and such work was not authorized by the RWP.

2. On June 4, 1982, an individual removed radioactive waste drums from the moisture separator/sparger area, an activity not authorized by the RWP (3-1-008).

3. On June 1 and 2, 1982, individuals worked in the Drywell Cavity without obtaining the extremity dosimetry required by applicable RWP 2-94-0392A.

4. On May 13, 1982, individuals worked on the Nonregenerative Heat Exchanger and performed eddy current testing without utilizing a double set of protective coveralls as required by applicable RWP 2-12-032C.

5. On May 26, 1982, an individual, upon leaving the "B" reactor water cleanup demineralizer, an RWP work area, failed to frisk for radioactive contamination, a standard RWP requirement, and contamination of his hands was not detected until existing the plant.

6. On June 7, 1982, two individuals were handling radioactive material in the Compactor Area of the Rad Waste Buiding without signing in or meeting the requirements of applicable RWP 2-20-0335.

g. Procedure HPO-CO/4 (SIC) requires the use of revised forms for RWP, RWP Access and Exposure Control, ALARA (as low as reasonably achievable) History Form, and an RWP request for ALARA Review Form. However, during June 1982, current revisions of RWP, RWP Access and Exposure Control, ALARA, and RWP Request and ALARA Review forms

were not being used in various locations throughout the facility.

This is a Severity Level III violation (Supplement IV). Civil Penalty $40,000.

Response to Violation II:

The violations contained under item II were originally reported in Inspection Report 50-277/82-11; 50-278/82-11. These matters were further the subject of an Enforcement Conference held in the Region I Office on July 22, 1982.

Philadelphia Electric Company's review of Violation II basically agrees with the analysis provided in your letter of March 29, 1983 which states:

> Violations of radiation protection program requirements described in Section II of the attached Notice, collectively represent the need for increased management attention in the implementation of your radiation protection program. Specifically, the violations consisted of failure to: (1) observe administrative and procedural controls for entry into a high radiation area; and (2) adhere to radiation protection procedures, including several examples of activities being performed either without a required Radiation Work Permit (RWP), or without adherence to the RWP requirements. Additional events also illustrated a weakness in your program. These events consisted of: (a) an individual handling irradiated shim material and receiving an unnecessary radiation exposure to his hand estimated at 2900 millirem; (b) a non-licensed operator overriding a hoist safety limit while removing a J-hook from the fuel pool without visually checking the hook as it was hosted, resulting in an irradiated control rod blade being lifted until a radiation monitor alarmed (a Notice of Violation was issued on May 24, 1982 for this event because of inadequate supervision of this activity by the senior licensed operator); and (c) a late report being provided to the NRC of an apparent radiation exposure in excess of limits to the badge of an individual. (Subsequent licensee and NRC investigations did not substantiate that the individual received such an exposure.) An apparent lack of commitment by station personnel for adherence to radiation protection requirements contributed to these events. This lack of commitment demonstrates the need for vigorous supervision of

activities involving radiation protection, increased emphasis to employees regarding the importance of adherence to procedures, and increased individual accoutability and responsibility for violations of procedural requirements.

The primary cause of the problems identified in the radiation protection area was the lack of adherence to radiation protection procedures by individual plant personnel. To a lesser extent, minor deficiencies in General Employee Training and procedural knowledge of plant personnel, and the difficulties associated with performing operating and maintenance activity in the radiation environment contributed to these deficiencies.

In response to the Enforcement Conference of July 22, 1982 which addressed the radiation protection area, a Health Physics and Radwaste Action Plan was developed. Sixty-six areas for investigation and resolution were identified. Attachment II provides a synopsis of those items in the Health Physics and Radwaste Action Plan which are applicable to Violation II. Attachment II provides a brief item description of the item, a status report concerning the completion of that item, and its applicability to the specific deficiency identified in the violation notice.

A follow-up NRC inspection conducted from December 14 - December 16, 1982, (Nos. 50-277/82-26; 50-278/82-25) noted significant improvements in the area of radiation protection including (1) formalization of the ALARA program, with assignment of full time professionals to the ALARA function; (2) initiation of a multifaceted program to improve radioactive waste control and reduce in-plant storage of such waste; (3) strengthening of existing radiation protection procedures; (4) review and revision of existing operating and maintenance procedures to incorporate health physics precautions and hold points; and (5) clarification of the functions and responsibilities of the Radiation Protection Manager and other individuals within the Health physics organization.

Conclusion

We believe that Philadelphia Electric Company has acted responsibly and expeditiously in reporting events, taking extensive corrective actions, and, where possible, implementing preventive measures. Conservative actions were taken promptly in order to enhance nuclear and personnel safety. It is important to note that the valving errors did not result in a significant

safety hazard as redundant systems were operable to perform the necessary safety functions, and that the radiation protection deficiencies did not result in any personnel over-exposure.

Notwithstanding Philadelphia Electric Company's belief that our record demonstrates our management and programmatic commitment to safety and quality in operation and radiation protection, enclosed is our check for $140,000 in payment of the imposed civil penalties.

If we can provide further information, please contact us.

Very truly yours,

Vincent S. Boyer

Attachments

cc: Mr. J. M. Allan, Acting Administrator
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Mr. R. A. Blough
Site Inspector

ATTACHMENT I

Valving Error Corrective Actions

The following items are corrective actions taken prior to, during, or after the events associated with the mispositioning of valves or failure to follow radiation protection procedures. A brief description of each of the corrective actions is provided below with its applicability to the specific violation. These corrective actions, along with those identified in Attachment II, are designed to increase the awareness of operations personnel of the requirement to follow procedures and to improve their adherence to existing administrative operating procedures.

1. Operations Personnel/Superintendent Meetings

In September and October of 1982, meetings were held with the station operations personnel and engineering support personnel. The purpose of these meetings was to discuss the Systematic Appraisal of Licensee Performance (SALP) findings for the year 1981/82 and review the importance of following administrative procedures, operating procedures, and radiation protection procedures. The compliance record for 1981/82 was reviewed and the need for compliance with Technical Specifications, operating procedures, and radiation protection procedures was stressed. Members of the operations and technical support groups attended one of these meetings.

These meetings are applicable as a corrective action for violations I.A, I.B, I.C, and II.

2. Highlighting of Locked Valves

All locked valves have been painted to highlight their significance. By color coding, these locked valves have also been identified as either normally open or normally closed.

This improvement in the visibility of locked valves should act as a reminder to operations personnel of the importance of these valves and the need to control their use by administrative procedure and the locked valve list. This corrective action is applicable to violation I.C.

3. Corrective Action Procedure

Administrative Procedure for Corrective Action, A-86 dated September 10, 1982, has been placed in effect. This procedure is used to investigate operating deficiencies including procedural deficiencies. Use of this procedure will result in the identification of the cause of the deficiency and the associated corrective action required. This procedure includes a mechanism for trending deficiencies so that generic problems can be identified and corrected.

This formalized procedure for investigating operating and other plant deficiencies including deficiencies in complying with radiation protection procedures was implemented on September 10, 1982. This procedure has been useful in highlighting personnel errors in the operation and radiation protection areas as well as in other areas. In each case, corrective actions, either specific or generic, are identified and implemented or programs are developed to resolve the cause of the deficiency. This corrective action is applicable to violation I.A, I.B, I.C, and II.

4. Non-Automatic Containment Isolation Valve Check-off List

A check-off list of non-automatic containment isolation valves (S.3.9.3.A(B) dated February 10, 1983) has been developed, approved, and issued. This list was successfully used by engineering personnel prior to a recent startup. Procedure GP-2A Reactor Startup Order has been modified to require performance of this non-automatic containment isolation valve check-off list prior to unit startup if a drywell entry was made during that shutdown.

The performance of this non-automatic containment isolation valve check-off list prior to unit startup following a drywell entry is a redundant check on the proper use of the administrative procedures for control of valves. This independent check of containment isolation valves should significantly reduce the probability of unit startup with containment integrity violations. Specifically, this corrective action addressed violation I.C.

5. Administrative Procedure Training

A training program intended to reinstruct personnel regarding requirements in pertinent Administrative Procedures has been developed and reviewed. This training program will be administered to all shift operations personel. This training will also be given to performance engineering staff, Instrument and Control (I&C) technicians, Health Physics and Chemistry (HP&C) technicians, and technical support staff. It is anticipated that this program will be completed by May 18, 1983.

This training program highlights the requirements of the Administrative Procedures in control of plant testing and operations. Until now, technical support personnel and operations personnel have received very little formal training regarding implementation of Administrative Procedures. Specifically, this corrective action addresses violations I.B, I.C, and II.

Adherence to procedures will be reinforced and emphasized in the General Employee Training program.

6. Valve Positioning Guidance

Routine testing procedure RT-8.0 has been revised (January 19, 1983) to provide guidance regarding the method of ensuring proper positioning of instrument valves. Guidance is provided indicating how normally opened valves should be positioned in the open position (i.e., one eighth turn closed from the full open position). Guidance is also provided so that individuals develop the skill of visually determining valve position by checking stem position and discoloration.

The guidance provided in RT8.0 regarding the positioning of valves in the normally open position should prevent hard backseating of instrument equalizer valves. This specific corrective action addresses violation I.A.

7. Instrument Rack Valve Color Coding

At the suggestion of the NRC resident inspector, color coding of instrument rack valves has been reviewed and improved. Some instruments had been removed by modifications which

changed the normal valve position on the instrument rack. As of April 6, 1983, all instrument racks have been reviewed and proper color coding applied to these valves. Missing hand wheels on these valves have been identified and installed.

Color coding of instrument rack valves was established several years ago. This re-review of the valve coloring code has been completed to ensure proper color coding following the implementation of several modifications. Although not directly applicable, this specific corrective action should help prevent valving errors such as those identified in violation I.A.

8. Instrument Valve Double Verification

The method of performing double verfications following surveillance tests associated with instruments has been modified such that the job leader will independently, following completion of the surveillance test by the technician, check and sign-off those valving steps in the procedure which ensure the return of the instrument to its operable condition. Guidance for this has been provided in letter form from the I&C Engineer to the I&C technician group. This method of performing the surveillance tests was implemented on January 18, 1983, after a short instructional period to the Susquehanna Test Branch technicians. Eventually, the Administrative procedure which governs the performance of surveillance tests may be modified to include this guidance.

This method basically provides a completely independent check of the instrument following surveillance tests to insure that it is again placed in an operable condition. Specifically, this corrective action addresses violation I.A.

9. Improved Operator Training

The helpers who are presently completing a training program for Auxiliary Operator are required to complete a locked valve check-off list module prior to taking the qualifying examination for auxiliary operator. Direction has been given to the Training Division to modify training manuals such that operators training for each outside operator position are required to complete the valve check-off lists associated with their systems as well as the locked valve check-off

list. Valves on a particular check-off list will be located during this training unless they are inaccessible due to plant operating status or high radiation. Although the requirement has been implemented, the revision to the training manuals has not been completed as of this date. These manuals will be revised by June 1, 1983. In addition, the Training Division has been requested to have the trainees identify valves to an instructor on an audit basis after they have completed a walk down of the systems.

This addition to the training program for various outside operators should increase the operators' knowledge of manual as well as motor-operated valves in the facility. The knowledge of these valve locations and the significance of these valves provided by the training program should improve their ability to maintain these valves in the appropriate positions. Specifically, this corrective action addresses violation I.C.

10. Tag-out Audit

Upon completion of the current Unit 3 outage, a comprehensive tagout audit will be performed, including the verification of proper application of red blocking tags. This 100% audit of outstanding unit blocking permits will be done within three months following each refueling outage and will provide an additional check for mispositioned valves.

A great many valves are positioned during a refueling outage. This comprehensive tagout audit should provide an independent mechanism for ensuring that out-of-service equipment valves associated with the outage unit are in the appropriate positions. This specific corrective action indirectly addresses violations I.A, I.B, and I.C.

11. Problem Analysis Training

Training is being provided for engineering professionals, physicists, and shift superintendents which is designed to improve their ability to identify the cause of deficiencies in operations and equipment performance.

To date, Kepner-Tregoe training in decision-making and problem analysis has been completed for 35 of the 58 members

of the plant staff identified above. The corrective action is indirectly applicable to violations I.A, I.B, I.C, and II.

12 Technical Specification LCO and Reporting Training

The licensed operator requalification program has been modified to incorporate a one day session on Federal Regulations, Technical Specifications, and reporting requirements designed to address perceived weaknesses in shift recognition of these requirements under certain plant conditions.

A requalification lecture on the subject was completed in the second cycle. This specific corrective action addresses violations I.A, I.B, I.C, and II.

13. Vice Presidential Letter

A letter from the Vice President of Electric Production was issued during September 1982 which requires all supervisors to ensure compliance with applicable procedures and administrative requirements at the Peach Bottom Atomic Power Station. The Quality Assurance Division has been requested to review and audit these procedural and administrative areas on a periodic basis. The frequency of the audit will be increased to daily during refueling outages.

The letter from the Vice-President to all supervisors was reviewed with the supervisors in most organizations working at this facility. Although specifically directed toward the area of radiation protection and housekeeping, the letter does remind individuals of their need to follow applicable procedures and administrative requirements. This corrective action is indirectly applicable to violations I.A, I.B, and I.C. and directly applicable to violation II.

14. Quality Control Re-organization

The Quality Assurance Division is presently expanding by establishing a Quality Control group which will provide more frequent independent checks of plant activities.

Implementation of the quality control activity under the Quality Assurance Division will be completed by December, 1983. This generic corrective action is applicable to violations I.A, I.B, I.C. and II.

15. Standardized Locks for Locked Valves

Locked valves are being equipped with a particular type of lock. Locked valves on the fire system will continue to be supplied with frangible locks so they can be opened under emergency conditions. All other locked valves will have standard locks applied. Providing the appropriate locks for locked valves is essentially complete. Approximately 20 additional locks are needed to complete this task. The Peach Bottom Unit 2 Drywell locks will be applied during the next outage of three days 'accessible drywell' duration. The Peach Bottom Unit 3 Drywell locks will be applied by the end of the current refueling. The remaining locks will be applied by August 15.

Providing the appropriate type of lock for the locked valves should reduce confusion and highlight their importance. This specific corrective action addresses violation I.C.

16. Operator Staffing and Training Improvements

Since 1979, the complement of shift operators has been increased significantly. The number of shift operators has almost doubled during this time interval. The increased staffing provides longer and better training periods as well as increased numbers of operators on shift to perform the double verification and plant rounds. The training programs in the operations group are being upgraded in response to INPO's training guidelines. We anticipate meeting the INPO accreditation program for licensed as well as non-licensed operators within two years.

This increased staffing and improvement in training programs indirectly addresses violations I.A, I.C, and II.

17. Independent Safety Engineering Group

It is Philadelphia Electric Company's intent to begin establishment of an independent safety engineering group at

Peach Bottom in March of 1984. This group will have responsibilities for monitoring plant operations and the investigation of plant transients and operating deficiencies. Investigation by this independent group should provide an overall improvement in plant operations and radiation protection areas.

This generic action is indirectly responsive to violations I.A, I.B, I.C, and II.

18. BWR Technology Training for I&C and Maintenance Personnel

A two-day training program has been developed to provide BWR technology training to I&C technicians. Lesson plans include sections on Fission, Fuel Technology, Primary Coolant Integrity, Primary and Secondary Containment Integrity and other BWR emergency core cooling systems and balance of plant support systems. Emphasis is placed on the instrumentation operability in support of these systems. Additional information is provided regarding the valving concerns associated with this instrumentation. This program has been implemented for "shift" I&C technicians at Peach Bottom. "Shift" I&C technician training is scheduled for completion on 9/4/83. Following completion of this phase, other I&C technicians and appropriate maintenance personnel will receive similar training.

By providing these individuals with the background information associated with the safety significance of their tasks in support of the overall safety of the nuclear reactor and its systems, improvements in personnel performance are anticipated. This training program for I&C technicians is directly responsive to violation I.A.

19. Electronic Log Book

Philadelphia Electric Company is developing the use of an electronic log book for monitoring of plant parameters. This development program is presently authorized for implementation in a fossil plant. If the program is successful, its implementation at the nuclear plant will be considered. This electronic log book has the capability of highlighting data which is different than a previous reading or different from comparative readings. By processing this

electronically logged data to a computer, an alarm will be provided to review personnel to specifically address the off-normal parameter.

This electronic notebook, if implemented, may be able to reduce the likelihood of overlooking off-normal parameters during the data review process. This long term corrective action is responsive to violation I.A and I.B.

20. Critical Equipment Monitoring Computer

Philadelphia Electric Company is implementing a critical equipment monitoring computer system (CEMS). This system is intended to be used by operations personnel to manually input valve positions and provide this information to control room personnel. The system is in the developmental stage and is not yet operational. Because of its complexity and the development nature of the project, no implementation date can be provided at this time. The system is expected to be placed in service on a system by system basis as appropriate valves are tagged, check-off lists are updated, and P&ID's are revised.

This computerized valve equipment monitoring program has some potential for improving the ability to insure that emergency core cooling systems and their components are in the appropriate operating conditions as required by plant status. This generic action is indirectly responsive to violations I.A, I.B, and I.C.

Summary

The corrective actions identified above constitute the major actions taken by Philadelphia Electric Company in response to the valving error violations identified in the March 29, 1983 letter. A significant number of these corrective actions have been completed or are very close to being completed. Some of the more generic corrective actions will require additional time due to required organizational changes. Philadelphia Electric Company believes that this program should prevent recurrence of events similar to those identified in the violations.

ATTACHMENT II

Radiation Protection Program Corrective Actions

Following the NRC Enforcement Conference in July of 1982, Philadelphia Electric Company formulated a Health Physics and Radwaste Action Plan which addressed past NRC inspection comments and deficiencies as well as comments of INPO audits. A list of 66 concerns and commitments were identified. These were documented in the Peach Bottom HP and Radwaste Action Plan. The Plan identified target completion dates, the individuals responsible for each item, and the status of each of the commitments or concerns. As of April 4, 1983, a significant number of these items have been resolved or completed. This attachment lists those commitments or concerns which are related to the specific violations listed under the radiation protection violations as well as the program weakness identified in your March 29, 1983 letter. This attachment provides a statement of the concerns or commitments, the status of that item, and its relationship to the particular violations.

1. Establish a formal ALARA program.

A formal ALARA program was established with the issuance of administrative procedure A-83 "ALARA Program Administrative Procedure". The procedure provides criteria for initiating ALARA evaluation and for the routine review of various tasks to be performed in the plant such that a determination can be made regarding the extent for ALARA review. If such a review is required, the Radiation Work Permit (RWP) which permits work in this radiation area, is not issued until the ALARA review is complete, and, in most cases, an ALARA traveler is provided. The traveler is a step-by-step outline of the major segments of the work to be done. Procedure A-83 was issued for implementation by the plant staff on June 8, 1982, and was approved by Quality Assurance Division on September 22, 1982. The ALARA program, therefore, has now been formally established. Refinements of this program are being made in response to comments generated as a result of two special INPO ALARA assist visits.

This item relates to violation II.g.

2. Provide sufficient ALARA implementing procedures.

As described in Item 1, a formal ALARA program has been implemented and, in itself, provides a significant number of implementing mechanism. However, the need to provide specific detailed implementing procedures was recognized. To date, two procedures which specifically deal with implementation of some portion of the ALARA program have been provided. In support of this effort, INPO has provided two assist visits specifically directed toward reviewing the implementation of the ALARA program. The first assist visit occurred during the week of January 24, 1983, a non-outage period. The second assist visit occurred during the week of March 22, 1983, during the present Unit 3 refueling outage. Preliminary results from these ALARA assist visits indicate that INPO has not identified any significant problems. Suggestions made by INPO will be implemented by developing detailed implementing procedures.

This item relates to violation II.g.

3. Provide a strong management commitment to the ALARA concept.

A company management commitment statement regarding implementation of the ALARA program was issued and distributed prior to January 3, 1983, following a review of many such statements issued in support of ALARA programs by other companies. The new policy statement was provided in the reprint of the PE Company Radiation Handbook. This Handbook is distributed to individuals who are given the General Employee Training program for the first time. This commitment is also stressed during GET training.

This item relates to violation II.g.

4. Staff ALARA group with qualified individuals.

Following implementation of the formal ALARA program, an ALARA group within the Health Physics technical support section was staffed with three experienced qualified health physics technical assistants. These individuals work with the craftsmen and subforemen to identify the scope of work

and perform the ALARA review. In many cases, this discussion between the working craftsmen and the HP ALARA group results in the generation of an "ALARA traveler". The traveler is a step-by-step outline of the major segments of work to be done and the HP and ALARA requirements associated with each step. The traveler is kept with the radiation work permit for each job and requires signoff by the craftsmen and HP technicians when each part of the job is completed. The ALARA traveler with the radiation work permit can then be used to identify the radiation dose accumulated during each portion of the job. The program has been implemented and staffed and appears to be working satisfactorily.

This item relates to violation II.g.

5. Improve inter/intra-departmental interfaces and communications between health physics, operations, and maintenance groups.

In order to improve communications between all working groups at Peach Bottom, and stress the need for individuals to follow procedures, the Station Superintendent held a series of two-hour discussions with a total of 732 site personnel. The topics discussed included health physics problem areas and requirements, radwaste minimization, housekeeping and fire protection, and the implementation of the nuclear plant rules. In addition, the results of the 1981/1982 SALP evaluation was reviewed with particular emphasis provided in the area of personnel errors associated with health physics practices, housekeeping, and fire protection. When these discussions were provided to operations and technical support personnel, operating deficiencies were also stressed. These discussions were completed by October 25, 1982.

In addition, a quality team was organized within the health physics group in order to address intergroup communications. This team completed its assignment and has generated a final report. This report is being evaluated by the plant staff.

Implementation of the ALARA traveler mechanism also provides closer communications during the planning of radiation area work and the performance of work in the radiation area by craftsmen and health physics personnel. In addition, HPO/CO-101 lists the duties of the health physics technician

assigned to the radiation control point. This procedure describes the information transfer necessary between the craftsmen and the health physics personnel before a craftsman may enter the radiation area. The above actions have resulted in improved communications and personnel adherence to radiation protection requirements.

Philadelphia Electric Company is also in the process of developing a preventive maintenance program which will include a computerized maintenance request form. This computerized program is called CHAMPS. Use of this computer will increase the ability to inform operations, health physics, and maintenance personnel of the job scopes for various work activities.

This item relates to violation II.b, c, d, e, and f.

6. Provide a written control point operating procedure.

A control point operating procedure (HPO/CO-101) was written, approved, and issued. A copy of this procedure was distributed to each technician for information purposes. This procedure lists the information transfer required. Existence of this procedure and the communications required at the control point was discussed at the management meeting discussed in Item 5.

This item related to violation II.a, b, c, d, e, and f.

7. Provide an Administrative Procedure to control keys to high radiation areas.

On August 15, 1982, Administrative Procedure A-84 "Control of High Radiation Keys" was approved by the plant staff. Quality Assurance Division approval of this procedure was provided on September 2, 1982. The procedure has been issued and implemented. This procedure, along with the requirements of Procedure HPO/CO-11, adequately addresses control of keys and control of access to high radiation areas.

This item relates to violation II.a and b.

8. Provide a formal mechanism for reporting health physics discrepancies.

On September 10, 1982, Administrative Procedure A-86 "Procedure for Corrective Action" was approved by the plant staff. Quality Assurance Division approval of this procedure was received on October 5, 1982. This procedure is utilized to investigate radiation protection discrepancies and can result in access restrictions, disciplinary action, as well as other progammatic corrective actions. Results of these discrepancies are accumulated, categorized, and reported on a quarterly basis for tracking purposes. This same Administrative procedure was discussed in Attachment I and is utilized in investigating other identified deficiencies.

This item relates to violations II.a, b, c, d, e, and f.

9. Provide a procedure which defines stop work authority of radiation technicians.

Procedure HPO/CO-101 has been revised, issued, and implemented. This procedure specifically addresses the stop work authority of the health physics technicians at each control point. This authority was communicated to individuals who attended the management orientation meeting held by the Station Superintendent in August, September, and October of 1982. This management meeting was discussed under Item 5.

This item relates to violations II.e and f.

10. Improve existing operating and maintenance procedures to include health physics hold points.

At the present time, ALARA and HP hold points are identified by the ALARA traveler program. Those tasks which fall under ALARA review requirements are not performed until the ALARA traveler has been written. The primary function of the ALARA traveler is to identify HP hold points and ALARA concerns. These ALARA travelers are developed by maintenance, construction, and vendors, with HP support, prior to initiation of work. In addition, a significant number of

those procedures routinely used on the refueling floor have been modified to include ALARA prerequisites and HP hold points within the procedures. Maintenance procedures continue to be reviewed and ALARA hold points included. This is an ongoing effort. The Plant Operations Review Committee is aware of the need to include health physics hold points in procedures and routinely addresses this during the procedure review process.

This item relates to violations II.e and f.

11. Include radiological safety concerns in the fuel floor operating procedures.

This topic is a subset of Item 10. In order to provide rapid response to radiation control mechanisms on the refueling floor, signs were posted on the refueling floor to inform all refueling floor personnel that an HP technician must be available to perform a survey when any component or grapple is removed from the fuel pool, reactor head cavity, or dryer separator storage pool. The HP control point for the refueling floor was relocated such that the HP's will be able to observe fuel floor activities which could result in changing radiation conditions. Most of the routine refueling procedures have been revised to include appropriate HP hold points in accordance with guidelines generated by the reactor engineering and health physics group.

This item relates to the general improvement of the health physics radiation protection program on the refueling floor.

12. Provide a mechanism, appropriate monitoring equipment, and training to permit operations personnel to perform a plant round without signing in and out on multiple RWP's.

It is believed that some of the personnel errors in adhering to radiation protection requirements within the operating group were caused by the difficulty in obtaining access to the various areas normally required to be entered as part of the shift operators round. It is our intent to develop a program to make it easier for outside operators to enter radiation areas which do not require respiratory equipment. Consultation with other sites has not identified an easily

adaptable mechanism or procedure. The mechanism which we expect to develop will permit the operator to enter many different radiation areas, provide for his own monitoring and record his own dose on the individual RWP. In order to accomplish this, operators will require additional training and some specialized monitoring equipment. The industry has been surveyed and appropriate special alarming dose rate meters have been identified and are on order. Procedure development has been assigned to a quality team to be composed of operations personnel, health physics personnel, and technical support personnel. Following completion of this quality team effort, the proposed mechanism will be evaluated in order to determine if such a mechanism should be implemented.

This item relates to violations II.a, b, and f.

13. Improve personnel adherence to radiation protection procedures.

In response to this concern, a quality team was organized in December of 1982. This quality team consisted of construction, maintenance, operations, technical support, instrument technicians, and health physics personnel. The quality team was assigned the responsibility to investigate reasons why procedures associated with radiation protection, housekeeping, and fire protection were not being routinely followed by all site personnel. The team has met on numerous occasions and is expected to be completed preparing their final report by June 1, 1983. This report will be evaluated by the plant staff and appropriate recommendations implemented.

This item relates to violations II.a, b, c, d, e, and f.

14. Improve knowledge and performance of individuals assigned to handling of low level radioactive waste.

A lesson plan was developed by the Training Division to qualify laborers involved in the handling and packaging of low level radioactive waste. Individuals who routinely handle low level radioactive waste have been identifed and have been trained with this new lesson plan.

This item relates to violation II.c, d, and f.

15. Provide permanent frisker locations within the power plant. Design and construct low background areas or cubicles in those areas where background radiation levels are too high.

Permanent frisker locations have been established in the power block. These locations are checked twice per week to verify that operational friskers are available. Some of these permanent frisking stations are in background areas which are higher than desirable. A list of frisking locations which require shielding has been provided to engineering with the request to provide appropriate shielding. In the interim, signs have been posted at the frisking location in the high background areas to direct personnel to the nearest frisker in a low background area.

This item relates to violation II.f.

16. Improve identification of smoking areas within the power block.

Smoking areas within the power block are office areas as well as two well-defined smoking areas at elevation 165 in Unit 2 turbine building and radwaste building. These in-plant smoking areas are well-defined and are enclosed.

This item improves the overall radiation protection program at Peach Bottom and is not in response to a specific violation.

17. Develop mechanisms to improve personnel awareness and performance in the radwaste shipping and compacting areas relative to ALARA and procedural adherence.

This topic was discussed at the management meeting identified in Item 5. The lesson plan for low level radwaste handling also addresses this concern. Signs have been posted in the radwaste compacting area which require that the rollup door in the radwaste area be closed during radwaste handling activities. In addition, the health physics QC technicians

have been given stop work authority if radwaste inspection and compacting procedures are not followed.

This item relates to violation II.c, d, and f.

18. Develop eddy current testing procedure for radioactive heat exchangers.

A generic heat exchanger eddy current testing procedure ST/ISI-11 has been developed by the maintenance engineering group and approved by site personnel. The procedure was successfully used on the 3D RHR heat exchanger during November of 1982.

This item relates to violation II.f.

19. Emphasize to site personnel the enforcement of the Nuclear Rules.

A letter was distributed to all station personnel shortly after July 15, 1982. This letter indicated to all personnel that individuals observed violating the Nuclear Plant Rules will be restricted from the protected area until an investigation into the occurrence is completed and appropriate corrective measures implemented. Procedure A-86 "Administrative Procedure for Corrective Action" is utilized to maintain this policy in effect.

This item relates to violation II.a, b, d, e, and f.

20. Develop appropriate mechanisms to achieve wide-spread support among employees for policy regarding radiation protection.

This need for employee support of the radiation protection program was the major theme of the management site personnel discussions identified in Item 5. On August 9, 1982, the Vice President of Electric Production issued a letter to all Electric Production Department Supervisors. This letter specifically requested first line supervision to support a radiation protection program, minimization of radwaste,

improvement in housekeeping, and adherence to the Nuclear Plant Rules.

This item relates to violations II.a, b, c, d, e, and f.

21. Improve personnel contamination control.

The training program for General Employee Training was modified to stress the need for frisking of outer clothing when exiting any potentially contaminated area. In addition, a remedial one-hour training program was provided to essentially all site personnel (676) during May and June of 1982. This remedial program specifically addresses frisking and contamination control requirements. In the fall of 1982, new more sensitive portal monitors were installed at the Guard House. Individuals identified as being slightly contaminated at this location are handled in accordance with the established practices identified in Administrative Procedure A-86 various HPO/CO procedures, and the Nuclear Plant Rules. Similar more sensitive monitors were also installed at the exit of the power block in December of 1982. Starting in January of 1983, the General Employee Training Program was modified such that those individuals who received General Respiratory Training are required to don and remove anti-C clothing while being observed by a examiner. These actions, along with the location of frisking stations in permanent positions throughout the plant, should improve control of personnel contamination.

This item relates to violation II.f.

Summary

The Items discussed in this attachment, along with other items included in the Peach Bottom Health Phyiscs and Radwaste Action Program, constitute and identify a broad-based program which will result in significant improvement in the radiation protection programs at Peach Bottom.

COMMONWEALTH OF PENNSYLVANIA :

ss.

COUNTY OF PHILADELPHIA :

V. S. Boyer, being first sworn, deposes and states:

That he is Senior Vice President of Philadelphia Electric Company, Licensee under Facility Operating Licenses DPR-44 and DPR-56 for Peach Bottom Atomic Power Station Units 2 and 3; that he has read the foregoing letter dated April 27, 1983 containing the Company's response to the United States Nuclear Regulatory Commission's Notice of Violation and Imposition of Civil Penalties dated March 29, 1983 and knows the contents thereof and; that the matters set forth therein are true and correct to the best of his knowledge, information and belief.

V. S. Boyer

V. S. Boyer

Subscribed and sworn to
before me this 27th day
of April, 1983.

Patricia D. Scholl

Notary Public

PATRICIA D. SCHOLL
Notary Public, Philadelphia, Philadelphia Co.
My Commission Expires February 10, 1986