



PECO ENERGY

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Docket Nos. 50-277
License Nos. DPR-44

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

Subject: Peach Bottom Atomic Power Station Units 2 & 3
Response to Notice of Violation (Combined Inspection Report No.
50-277 & 50-278/95-08)

Gentlemen:

In response to your letter dated May 25, 1995, which transmitted the Notice of Violation concerning the referenced inspection report, we submit the attached response. The subject report concerned a Routine Resident Safety Inspection that was conducted March 19 through April 22, 1995.

If you have any questions or desire additional information, do not hesitate to contact us.

Gerald R. Rainey
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Peach Bottom Atomic Power Station

Attachment

CCN#95-14058

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PDR ADDCK 05000277
Q PDR

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cc: R. A. Burricelli, Public Service Electric & Gas
R. R. Janati, Commonwealth of Pennsylvania
T. T. Martin, US NRC, Administrator, Region I
W. L. Schmidt, US NRC, Senior Resident Inspector
H. C. Schwemm, VP - Atlantic Electric
R. I. McLean, State of Maryland
A. F. Kirby III, DelMarVa Power

RESPONSE TO NOTICE OF VIOLATION

Restatement of Violation

Technical Specification 6.8.1 requires that written procedures and policies be established and implemented that meet the requirements of Section 5.1 of ANSI N18.7-1972. ANSI N18.7-1972, Section 5.1 states that plant procedures shall be followed.

Contrary to the above, on March 19, 1995, PECO Energy failed to properly follow abnormal operating procedure AO 57B.13-2, "125/250 VDC 2B and D Station Battery Ground Investigation". Specifically, operators failed to understand a note before a procedure step indicating that because of the next step the high pressure coolant injection system suction would transfer from the condensate storage tank to the torus, and that the suction would need to be transferred back to the condensate storage tank to restore the system to normal. However, the operators left the Unit 2 HPCI system suction path mis-aligned to the torus and did not restore the normal suction path from the condensate storage tank as specified by the procedure, for over 18 hours.

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

Background

On March 19, 1995, operators were performing AO 57B.13-2 to troubleshoot a ground in the 2B - 2D battery circuit. A floor shift supervisor and an equipment operator were performing the procedure in the reactor building and the cable spreading room (CSR) to monitor the ground detection system. The operators read a note preceding step 21 of the procedure that stated, "Suction valves will swap from the CST to the torus if the 250 VDC MCC's 20D1105 and 2D1106 are energized when the switch is opened. AO-23-39 and AO-23-40 will close if open. SV-4543 will de-energize and AO-4248 will close and open if Rx High Level conditions exist. "HPCI Logic Bus Power Fail" and "Condensate Stor Tank Level Low-Low" at 221 (20C204B) will alarm. If CST to torus swap occurs, MO-23-17 will have to be manually opened." The operators stated they were not familiar with the bus identification number designated in the note and did not recognize what the bus represented. Information was also not conveyed to the Unit 2 reactor operator (RO) in the control room concerning a possible swap from the CST to the torus. Upon completion of step 21, the operators questioned the RO if he had the same light indications he started with before the step was performed. The RO performed a quick check of the light indications and replied in the affirmative. The operators felt that the step had been adequately performed and that CST to torus transfer had not occurred since there was not a change in light indications. During the early shift panel walkdown inspection on March 20, 1995, however, the day-shift Unit 2 RO self-identified an abnormal HPCI system lineup and immediately notified shift management. It was also self-identified that the abnormal lineup had not been discovered by two previous shifts.

Reason for the Violation

The operators in the field that performed the test did not adequately self-check. Performance of the procedure should have been suspended until equipment numbers that were unfamiliar to the operators were fully evaluated.

The note prior to step 21 was confusing and contained a conditional action statement. Personnel performing the test and the control room supervisor thought that the CST to torus swap was only a possibility, and not a certainty. Additionally, Administrative Procedure A-C-1, "Procedure Writer's Guide" defines a note as a method to provide additional or clarifying information to the procedure user and should not contain an action step that is part of a task sequence.

Communication between the operators and the Unit 2 RO was less than adequate. The operators did not discuss the note with the RO prior to performing step 21 of the test and did not provide any background information to the RO after they questioned him concerning panel indicating lights.

Operator attention to detail of panel walkdowns for two shifts following performance of the test was less than adequate in that they failed to identify that HPCI was mis-aligned to the torus.

The Corrective Steps That Have Been Taken and the Results Achieved

Normal HPCI system suction from the CST was immediately re-established on March 20, 1994, following notification of the mis-alignment to shift management.

A Performance Enhancement Program (PEP) issue was initiated March 20, 1995, to determine causal factors of this event and to develop corrective actions to prevent recurrence.

A required reading package that focused on effective communication and expected control room response for plant evolutions was issued May 12, 1995. This package was developed from the PEP issue with an emphasis on clear and concise communication between the control room and floor operators.

The Senior Manager of Operations used this event as a case study in his staff meeting with the Shift Managers. Self-check and control room oversight of activities were the focus topics of this meeting.

The Operations department has initiated an "Event Free Operations" Program. An objective of this program is to improve operator human performance and to continuously promote the use of self-check.

The importance of high attention to detail during panel walkdowns was discussed via the ASPEN voice/message system with shift personnel following the event. Management expectations for thorough and complete panel walkdowns were reiterated.

An employee work stand-down was conducted on June 20, 1995, to reinforce employee awareness and management expectations concerning self-check. It was stressed that self-check should continue to be a part of the daily work activities.

The Corrective Steps that Will Be Taken to Avoid Further Violations

Abnormal operating procedure AO 57B.13-2, "125/250 VDC 2B & 2D Station Battery Ground Inspection" will be revised to clarify the information in the note prior to step 21 and to include a verification step after the note that HPCI system suction is in proper alignment. Component identification numbers will be evaluated and revised as appropriate. Additional battery ground procedures will also be reviewed and revised to clarify note information and to verify proper system line-up as appropriate. These actions will be completed by August 4, 1995.

The corrective steps that have been taken as a result this event will also serve to avoid further violations.

Date When Full Compliance Was Achieved

Full compliance was achieved March 20, 1995, when the condensate storage tank was re-aligned to the HPCI system as the normal suction source.