



PECO NUCLEAR

A Unit of PECO Energy

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Docket Nos. 50-277
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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.
50-277/96-04 & 50-278/96-04)

Gentlemen:

In response to your letter dated August 6, 1996, which transmitted the Notice of Violation concerning the referenced inspection report, we submit the attached response. The subject report concerned a Routine Resident Integrated Safety Inspection that was conducted May 5 through July 6, 1996.

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

Thomas N. Mitchell
Vice President,
Peach Bottom Atomic Power Station

Attachments

cc: B. W. Gorman, Public Service Electric & Gas
R. R. Janati, Commonwealth of Pennsylvania
H. J. Miller, 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

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RESPONSE TO NOTICE OF VIOLATION

Restatement of Violation

Technical specification 5.4.1 requires, in part, that written procedures be implemented to cover technical specification required surveillance testing, operation of the reactor protection system, and for maintaining secondary containment integrity.

Contrary to the above, PECO did not properly implement written procedures for:

- Technical specification required testing on a control room emergency ventilation system filter train. Specifically, on May 9, 1996, PECO contractor technicians, under the supervision of a PECO maintenance technician, did not implement procedure ST-M-40D-905-2 properly.
- Operation of the reactor protection system. Specifically, on May 22, 1996 a plant equipment operator did not properly implement procedure SO 60F.6.A-2 during restoration of the 2B reactor protection system motor generator set, resulting in a loss of power and a half reactor scram.
- Maintaining secondary containment integrity. Specifically, on June 12, a chemistry technician did not implement procedure A-C-134 properly, resulting in an improperly controlled breach of the secondary containment.

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

Reason for the Violation (Example 1)

On May 9, 1996, at approximately 1000 hours, ST-M-40D-905-2, Control Room Emergency Ventilation Filter Train 'A' Test, was identified as being performed out of sequence. ST-M-40D-905-2 is a Level 1 procedure which requires the procedure to be in hand, and the performance and completion of steps to be documented as they are performed. The filter train test was being performed by an outside contractor with the support of Peach Bottom Atomic Power Station (PBAPS) maintenance. The contractor is utilized for their expertise on charcoal filter train testing, results analysis, knowledge of safety-related ventilation systems and the regulatory requirements of these systems. The vendor performs these tests with generic procedures and guidelines developed by the vendor for these tasks. PBAPS has specific surveillance tests that delineate the steps required to perform the filter testing. The result of this process was that the PBAPS maintenance procedure and the vendor procedure did not agree with respect to sequence and chronological order of the steps. The testing was performed on the filter train until the evolution was questioned by the NRC resident inspector. The testing was stopped and reviewed by the maintenance technicians, maintenance supervision and the vendor. It was determined that the Control Room Emergency Filter Train ST was not being performed as written.

Corrective Steps That Have Been Taken and the Results Achieved

Upon discovery of the issue, the test was stopped and the procedure was revised using the Temporary Procedure Change process. Vendor personnel assisted in this process to ensure that the PBAPS ST was revised to the proper test methodology and sequence. The temporary change and permanent revision to the procedure was approved and the test completed satisfactorily at 2030 hours on May 9, 1996.

A meeting was held with the work team on August 2, 1996 where management expectations and requirements of A-C-79 were communicated. The maintenance division also conducted an all-hands meeting on August 9, 1996 to discuss this issue and communicate management expectations for procedure usage and compliance.

A review of other procedures associated with vendor test performance was performed. Several procedures were identified with similar situations of potential conflict and Procedure Problem Identification Process (PPIS) action items were initiated to resolve these issues.

Corrective Steps That Will Be Taken to Avoid Further Violations

Vendor input and comment will be obtained prior to test performance to ensure station procedures are consistent with vendor and industry practices. Appropriate procedures will be revised prior to test performance to ensure consistency.

Date When Full Compliance Was Achieved

Full compliance on ST-M-40D-905-2 was achieved on May 9, 1996 when the test procedure was revised to sequentially correspond to the activities required to be performed. The test was then satisfactorily performed and completed.

Reason for the Violation (Example 2)

On May 22, 1996, at approximately 1305 hours, an unexpected loss of the Unit 2 'B' RPS power supply occurred when an equipment operator mispositioned the voltage adjustment rheostat for the RPS Alternate feed transformer. The operator was required, per procedure SO 60F.6A-2, "Transferring Reactor Protection System Power Supplies", to adjust the 'B' RPS MG set rheostat to set-up the 'B' RPS MG set for return to service from maintenance. A pre-job briefing was conducted and the operator was instructed on the appropriate sequence of restoration. The operator proceeded to walk down the SO to ensure he was familiar with all of the locations for restoration, specific actions required, and test equipment installation points. After this evolution was complete, he returned to the 'B' RPS MG set and verified appropriate steps in the SO. The next task described in the SO was to adjust the rheostat on the 'B' RPS MG set. Instead, the operator proceeded to the RPS Alternate feed and turned the rheostat for the RPS Alternate feed thus causing the unexpected transient. The cause of this event was the failure of the operator to follow SO 60F.6.A-2. This resulted in an unanticipated unit half scram and an outboard Group III PCIS isolation which required a four hour notification to the NRC.

Corrective Steps That Have Been Taken and the Results Achieved

Upon loss of the alternate RPS feed, the operating shift investigated the cause of the transient and restored the RPS feeds in accordance with station procedures.

The equipment operator was counseled on the expectation to adhere to procedures, be aware of his surroundings and to fully implement self-check techniques.

Corrective Steps That Will Be Taken to Avoid Further Violations

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

Date When Full Compliance Was Achieved

Full compliance was achieved on May 22, 1996, when the RPS feeds were returned to normal.

Reason for the Violation (Example 3)

On June 12, 1996, at approximately 1005 hours, the hatch between the Unit #3 refuel floor and the refuel floor roof was propped open to allow access to the roof for performance of CH-428, "Main Stack and Vent Stack Sampling System Efficiency Determination". Personnel performing this test believed that the only procedural requirement to open the hatch was to have a security guard present. They were not aware that propping this door open resulted in a violation of secondary containment even though this hatch was posted as an A-C-134, "Control of Hazard Barriers" hatch. The security guard also failed to recognize the consequence of propping the hatch door open and the potential to impact secondary containment integrity. This work activity should have been controlled by A-C-134 and GP-16 "Breaching and Establishing Secondary Containment". These procedures do not allow a secondary containment door to be propped open without specific controls put in place to ensure compliance with maintaining secondary containment.

Corrective Steps That Have Been Taken and the Results Achieved

Upon discovery, the following actions were taken. The hatch to the roof was immediately closed and shift management was notified. Personnel working on the roof were briefed on A-C-134 requirements and the need to keep the hatch closed for secondary containment operability. The security guard was also briefed to ensure the hatch remained closed for secondary containment operability, except for brief passage.

An evaluation was performed to determine if secondary containment had been compromised during this event. The evaluation concluded there was sufficient margin to ensure the safety function of secondary containment was maintained.

An all-hands meeting was held with the chemistry staff to address the issues of A-C-134 and GP-16 and the need to properly maintain hazard barriers closed except for passage and the need to ensure secondary containment is maintained.

Nuclear security group issued a bulletin to all security personnel to ensure that designated and posted as A-C-134 doors are not propped open. In addition, the locks to the refuel floor roof hatches have been changed which require a specific key to open these hatches. This key is only issued by nuclear security and contains a tag which warns not to open these hatches without GP-16 and shift supervision's authority.

Procedure CH-428 was revised, using the temporary procedure change process, to obtain permission from shift management to temporarily breach secondary containment in accordance with GP-16 and A-C-134. CH-428 was then permanently revised to reflect the same requirements in the prerequisite section of the procedure as well as adding precautionary notes in the procedure sections that require roof access.

GP-16 was revised to render secondary containment inoperable in modes 1(Power Operation), 2(Startup), and 3(Hot Shutdown) as a result of opening either the Unit #2 or #3 refuel floor hatch to reactor building roof.

The information and causes of this issue were provided to site-wide work groups. Action items were issued to site groups to ensure review of this issue and an understanding A-C-134 and its requirements, as well as the need to control secondary containment as it relates to the PBAPS design basis.

Corrective Steps That Will Be Taken to Avoid Further Violations

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

Date When Full Compliance Was Achieved

Full compliance was reached at 1100 hours on June 12, 1996, when the hatch to the Unit #3 refuel floor roof was closed.