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JUL 27 1993

Docket No. 50-353

Mr. D. M. Smith
Senior Vice President - Nuclear
Philadelphia Electric Company
Nuclear Group Headquarters
Correspondence Control Desk
P. O. Box 195
Wayne, Pennsylvania 19087-0195

Dear Mr. Smith:

Subject: Routine Inspection No. 50-353/93-12

This letter refers to your July 11, 1993 correspondence, in response to our June 10, 1993 letter.

Thank you for informing us of the corrective and preventive actions documented in your letter. These actions will be examined during a future inspection of your licensed program.

Your cooperation with us is appreciated.

Sincerely,

Original Signed By:
Robert J. Bores

James H. Joyner, Chief
Facilities Radiological Safety
and Safeguards Branch
Division of Radiation Safety
and Safeguards

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Philadelphia Electric Company

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cc:

J. Doering, Chairman, Nuclear Review Board
D. R. Helwig, Vice President - Limerick Generating Station
G. A. Hunger, Jr., Manager - Licensing Section
J. L. Kantner, Regulatory Engineer - Limerick Generating Station
Secretary, Nuclear Committee of the Board
Public Document Room (PDR)
Local Public Document Room (LPDR)
Nuclear Safety Information Center (NSIC)
K. Abraham, PAO
NRC Resident Inspector
Commonwealth of Pennsylvania

bcc w/encl:

Region I Docket Room (with concurrences)
V. McCree, OEDO
F. Rinaldi, NRR
M. Boyle, Acting PDI-2, NRR

DRSS:RI
Peluso/gc
Peluso
7/27/93

DRSS:RI
Bores *Bores*
7/27/93

DRSS:RI
Joyner *Joyner*
7/27/93

PHILADELPHIA ELECTRIC COMPANY

LIMERICK GENERATING STATION

P. O. BOX 2300

SANATOGA, PA 19464-2300

(215) 327-1200, EXT. 3000

July 11, 1993

DAVID R. HELWIG
VICE PRESIDENT
LIMERICK GENERATING STATION

Docket No. 50-353
License No. NPF-85

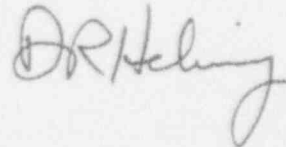
U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

SUBJECT: Limerick Generating Station, Unit 2
Reply to a Notice of Violation
NRC Inspection Report No. 50-353/93-12

Attached is Philadelphia Electric Company's reply to a Notice of Violation for Limerick Generating Station (LGS), Unit 2, which was contained in your letter dated June 10, 1993. The cited violation involved the failure to perform prompt corrective actions in response to a violation of Offsite Dose Calculation Manual requirements. The attachment to this letter provides a restatement of the violation followed by our reply.

If you have any questions or require additional information, please contact us.

Very truly yours,



GHS:cah

Attachment

cc: T. T. Martin, Administrator, Region I, USNRC
N. S. Perry, USNRC Senior Resident Inspector, LGS

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Reply to a Notice of ViolationRestatement of the Violation

During an NRC inspection conducted on May 10-14, 1993, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violation is listed below:

Control 3.3.1 of the Offsite Dose Calculation Manual, Action Statement (b) requires, in part, that, with less than the minimum number of radioactive gaseous effluent monitoring instrumentation channels operable, the action shown in Table I3.3-1 will be taken. Table I3.3-1, Action Statement 111 for the Noble Gas Activity Monitor requires, in part, that with less than the minimum required channels operable, grab samples be taken at least once per 8 hours and that these samples be analyzed for gross activity within 24 hours.

Contrary to the above requirement, on November 23, 1991 at 0830 hours, the 2B South Stack effluent sample pump became inoperable and with the 2A South Stack effluent sample pump also inoperable, this resulted in the loss of the noble gas monitoring channel. Noble gas sampling was not initiated until November 25, 1991, two days later.

This is a Severity Level V Violation (Supplement I).

ResponseAdmission of Violation

Philadelphia Electric Company acknowledges the violation.

Reason for the Violation

On November 23, 1991, at 0830 hours, with the 'A' channel of the Limerick Generating Station (LGS) Unit 2 South Stack gaseous effluent monitoring system previously inoperable, the 'B' channel of the Unit 2 South Stack gaseous effluent monitoring system lost sample flow and was declared inoperable by the LGS Operations personnel. With both channels of the Unit 2 South Stack gaseous effluent monitoring system inoperable, the LGS Operations Department notified the LGS Chemistry Section to initiate gaseous effluent sampling. The Offsite Dose Calculation Manual (ODCM) Section 3.3.1 requires auxiliary sampling for particulates and

iodine to be established, and for noble gas grab samples to be taken at least once per eight (8) hours when both channels of the South Stack gaseous effluent monitoring system are inoperable. Auxiliary sampling for particulates and iodine was initiated at that time in accordance with the requirements of the ODCM.

On November 25, 1991, a Chemistry Section supervisor identified a failure to initiate grab sampling for noble gas on November 23, 1991, as required by the ODCM for the inoperable Unit 2 South Stack gaseous effluent monitoring system. Noble gas grab sampling was immediately initiated upon identification. A Reportability Evaluation/Event Investigation Form (RE/EIF) was initiated on November 25, 1991 for this event and was forwarded to the site Regulatory Engineer for reportability determination. The site Regulatory Engineer determined that this specific issue was not reportable in accordance with 10CFR50.73, but that a description of this event should be included in the Semiannual Radioactive Effluent Release Report due to non-compliance with the ODCM. This information was provided in the Semiannual Radioactive Effluent Release Report submitted by letter dated February 28, 1992, summarizing radioactive liquid and gaseous effluent and solid waste quantities released from LGS for the period July 1, 1991 through December 31, 1991.

During the period of May 10-14, 1993, an inspection of the LGS Radioactive Liquid and Gaseous Effluent Controls Program was conducted by the NRC. During this inspection, the NRC Inspector reviewed several Semiannual Radioactive Effluent Release Reports, including the description of the November 23, 1991 event, and identified that no corrective actions to prevent recurrence for this event had been identified nor implemented.

The cause of the failure to initiate noble gas grab sampling on November 23, 1991, was an inadequate procedure. Chemistry sampling procedure CH-1015.1, "Sampling of Gases, Iodine, and Particulate of the G.A. Gaseous Effluent Radiation Monitors," was written to implement the requirements of the ODCM on sampling for either particulates, iodine, or noble gas due to an inoperable radioactive effluent monitoring system. However, this procedure did not clearly specify that sampling for all three parameters was required when both channels of the gaseous effluent monitoring system were inoperable. In addition, the Chemistry technicians on shift between November 23, 1991 and November 25, 1991 failed to realize that noble gas sampling was also required in accordance with the ODCM.

The cause of the failure to identify and implement corrective actions for the November 23, 1991 event was a failure to correctly follow procedure. Nuclear Group Administrative Procedure (NGAP) NA-02A002, "Investigation of In-House Events," Revision 2, in effect in November 1991, required that copies of a RE/EIF, once generated, be issued to both the site Regulatory Engineer and the Event Investigation Coordinator (EIC) for the In-House Event

Investigation Program. In this event, a copy of the RE/EIF was not forwarded to the EIC by the Chemistry Section. Therefore, an event investigation was not conducted, and no formalized corrective actions were identified nor implemented to prevent recurrence.

A contributing factor to this event was that no formalized verbal communication path existed between the Regulatory Engineer and the EIC. The Regulatory Engineer and the EIC were situated in different buildings, and met on an infrequent schedule to compare events to RE/EIF numbers and immediately resolve any discrepancies. At the time of this event, there was only one person performing the EIC duties on less than a full time basis.

Another contributing factor in this event was that communications within the In-House Event Investigation Program were less than adequate. The determination by the site Regulatory Engineer that the event was not reportable in accordance with 10CFR50.73 contributed to a lack of follow-up by the Chemistry Section. The Chemistry Section was under the impression that since the event was not reportable, no event investigation was required.

Corrective Actions and Results Achieved

Regarding the failure to initiate noble gas grab sampling, this sampling was initiated upon identification on November 25, 1991. In addition, a description of this event was provided in the Semiannual Radioactive Effluent Release Report submitted by letter dated February 28, 1992.

With respect to the failure to identify and implement corrective actions for the November 23, 1991 event, this issue was entered into the In-House Event Investigation system on May 18, 1993 and was closed on May 20, 1993, i.e., the investigation was performed and the appropriate corrective actions to prevent recurrence were identified and implemented or scheduled to be implemented.

Corrective Actions Taken to Avoid Future Non-compliance

Regarding the failure to initiate noble gas sampling, procedure CH-1015.1 was revised on June 25, 1993 to clearly specify the gaseous effluent sampling requirements when the gaseous effluent monitoring system is inoperable. In addition, a discussion of this event was incorporated into the Chemistry technicians continuing training program.

Regarding the failure to investigate the November 23, 1991 event and implement corrective actions, an overview of the In-House Event Investigation Program with the Chemistry Section, to include

discussion of this specific event, will be conducted by August 1, 1993. In addition, a new Plant Information Management System (PIMS) computer module is scheduled for implementation on September 1, 1993. This module will track in-house event investigations by requiring successively higher levels of review for each issue which has been identified. All issues will require reviews by a Reportability Coordinator, a Regulatory Engineer, and the Experience Assessment Coordinator. This computer tracking method will prevent future hard copy forwarding problems.

With respect to the contributing factors of this event, site reorganization of personnel and functions has combined the reportability determination and in-house event investigation functions within the same site organizational unit. Also, three individuals have now been assigned to administrate the In-House Event Investigation Program. Issues are presented daily to site management, and communication of issues at all levels has improved.

Since the November 23, 1991 event, NGAP NA-02A002 has been replaced by Common Nuclear Procedure (CNP) LR-C-10, "Investigation of In-House Events." Additionally, the EIC has made several presentations to various site organizations explaining the benefits of learning from all levels of events. Also, the Plant Manager has distributed two separate letters dated March 25, 1993, and April 14, 1993, detailing managements expectation of using the structured learning process of event investigation and applying it to all levels of events.

Date When Full Compliance was Achieved

Regarding the sampling of noble gas, full compliance with the ODCM was achieved at 0725 hours on November 25, 1991, when noble gas sampling was initiated.

Regarding the failure to investigate the November 23, 1991 event and implement corrective actions, full compliance was achieved on May 20, 1993, when the investigation of the event was completed, and the appropriate corrective actions were identified and implemented or scheduled.