



PECO ENERGY

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February 18, 1994

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

EA 93-290

Subject: Peach Bottom Atomic Power Station, Units 2 & 3  
Response to Notice of Violation (Combined Inspection  
Report No. 50-277/93-27 & 50-278/93-27)

Dear Sir:

In response to your letter dated January 19, 1994, which transmitted the Notice of Violation concerning the referenced inspection report, we submit the attached response and affidavit. The subject inspection concerns a routine radiological controls inspection that was conducted October 4-8, and November 8-10, 1993. An enforcement conference was held December 10, 1993, at NRC Region I headquarters to discuss the circumstances of the violations, their causes, and the corrective actions taken.

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

Sincerely,

DMS/RKS:bah

Attachments

cc: T. T. Martin, Administrator Region I, USNRC  
W. L. Schmidt, Senior Resident Inspector, USNRC

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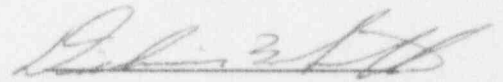
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bcc: W. P. Dornsife, Commonwealth of Pennsylvania  
R. I. McLean, State of Maryland  
H. C. Schwemm, Atlantic Electric  
C. D. Schaefer, Delmarva Power  
R. A. Burrice, Public Service Electric & Gas  
D. M. Smith - CB, 63C-3  
G. R. Rainey - PB, SMB4-9  
J. A. Bernstein - CB, 63C-7  
J. B. Cotton - CB, 51A-1  
G. V. Cranston - CB, 63B-1  
J. Doering, Jr. - CB, 63C-5  
E. J. Cullen - MO, S23-1  
A. A. Fulvio - PB, SMB4-6  
G. A. Hunger, Jr. - CB, 62A-1  
M. C. Kray - CB, 62A-1  
C. J. McDermott - MO, S13-1  
R. M. Moore - PB, PS-1-3  
F. W. Polaski - PB, SMB4-6  
G. E. Edwards - PB, A4-1S  
J. T. Robb - CB, 61C-1  
Commitment Coordinator - CB, 62A-1  
Correspondence Control Desk - CB, 61B-3  
DAC - CB, 61B-5

COMMONWEALTH OF PENNSYLVANIA :  
 : SS.  
COUNTY OF CHESTER :

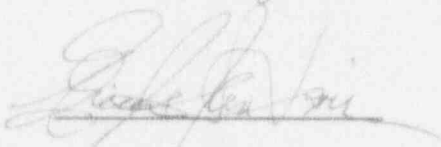
Dickinson M. Smith, being first duly sworn, deposes and says:

That he is Senior Vice President-Nuclear, PECO Energy Company; that he has read the response to the Peach Bottom Atomic Power Station, Units 2 and 3 Notice of Violation and knows the contents thereof; and that the statements and matters set forth therein are true and correct to the best of his knowledge, information and belief.



Senior Vice President

Subscribed and sworn to  
before me this 18<sup>th</sup> day  
of February 1994.



Notary Public

Notarial Seal  
Erica A. Santori, Notary Public  
Tredyffrin Twp., Chester County  
My Commission Expires July 10, 1995

## Response to Notice of Violation

### Restatement of Violation

Technical Specification (TS) 6.11 requires that procedures for personnel radiation protection shall be prepared consistent with requirements of 10CFR Part 20 and shall be approved, maintained, and adhered to for all operations involving personnel radiation exposure.

Licensee Radiation Protection Procedure A-C-107, "Radiation Work Permit (RWP) and Radiological Controlled Area (RCA) Access Requirements" requires that individuals be responsible for (a) complying with established posting in the RCA; (b) complying with the requirements of the appropriate RWP; (c) notifying Health Physics (HP) of any radiological problems encountered during RCA entries; (d) notifying HP of any change in radiological conditions during RCA entries; and (e) complying with written and oral radiological instructions given by HP.

1. Contrary to the above, on October 27, 1993, a plant equipment operator entered an area in proximity to the Unit 3 fuel pool heat exchanger, an area visibly posted as "high radiation area (HRA), radiation work permit (RWP) required", and the individual did not comply with the requirements of the applicable standing operations radiation work permit. Specifically, the individual did not obtain the required area pre-entry briefing and did not obtain the required alarming dosimeter or positive radiation protection coverage. (01013)
2. Contrary to the above on October 28, 1993, a system manager (engineer) entered an area in proximity to the Unit 3 fuel pool heat exchanger, an area visibly posted as a "HRA, RWP required," and the individual did not comply with the requirements of the applicable standing RWP. Specifically, the individual did not obtain the required area pre-entry briefing and did not obtain the required alarming dosimeter or positive radiation protection coverage. (01023)
3. Contrary to the above, on October 29, 1993, an engineer entered the Unit 3 drywell 135' elevation, near residual heat removal valve No. 46B, an area visibly posted as "respiratory protection required," and the individual did not comply with the requirements of the applicable RWP or with the radiological instructions given by Health Physics. Specifically, the individual entered the posted area without the required respiratory protection equipment, despite having been told not to do so by radiation protection personnel. (01033)

This is a Severity Level III problem (Supplement IV)

### Reason for the Violation (Example 1)

On October 27, 1993, an operator entered a posted high radiation area on the Unit 3 Reactor Building 165 ft elevation without a pre-job brief, positive Health Physics (HP) coverage, and an alarming dosimeter as required by the appropriate radiation work permit (RWP). The operator was required to enter the area to open three drain valves in preparation for planned maintenance on the Unit 3 Service Water System. The operator decided that the task could be accomplished more expeditiously by entering the area and opening the three drain valves as opposed to the time he perceived it would take to satisfy the RWP requirements. The operator was familiar with the radiological conditions of the area and rationalized that any radiological consequences of the entry would be minimal based on the short duration of time in the area. The operator was cognizant that the area was posted as high radiation, but failed to consider the consequences of his actions. The operator rationalized, therefore, in the interest of time and without consideration of any adverse consequences, to enter the high radiation area in lieu of the required prerequisites to complete the task.

### Corrective Steps That Have Been Taken and the Results Achieved

The operator was prohibited from working in radiologically controlled areas until the incident was investigated and resolved. Operations and HP management were notified of the event and an investigation was initiated. The NRC was promptly notified of the incident.

An appropriate and significant level of disciplinary action was taken against the individual.

The Plant Manager and Senior Manager of Operations held meetings with operating crews and shift managers where management expectations were reinforced concerning nuclear plant rules and procedural compliance.

A letter was issued from the Site Vice President to site personnel regarding compliance with nuclear plant rules. In addition, a memorandum was issued by the Plant Manager describing possible NRC enforcement action against any individual who willfully violates NRC regulations and license conditions.

A Step Up Plan to improve station performance was adopted by senior management and was in early stages of implementation at the time of this event. Management initiatives within this plan include:

- \* Establishment of clear performance expectations
- \* Increased performance monitoring by supervision
- \* Increased emphasis on personal accountability
- \* Positive reinforcement for good performance
- \* Negative consequences for poor performance

Criteria for proper radworker practices have been incorporated into plant operator performance indicators. This criteria includes not climbing above 7 feet without HP permission, no entry into high radiation areas without HP involvement and no breach of contaminated boundaries without proper anti-contamination clothing and HP notification as required.

Corrective Steps That Will Be Taken to Avoid Further Violations

Radworker practices pertinent to operators will be reviewed annually in Licensed Operator Requalification (LOR) Training and Non-Licensed Operator Continuing Training (NLOCT). This review will be conducted by February 28, 1994, for the current year.

Date When Full Compliance Was Achieved

Full compliance was achieved October 27, 1993, when the operator exited the high radiation area.

### Reason for the Violation (Example 2)

On October 28, 1993, a system manager entered a high radiation area without an alarming dosimeter or the required pre-job brief to stop a service water leak (approximately 25 gpm) from a vent valve on the 165' elevation of the Unit 3 reactor building. The system manager had written and was responsible for the procedure for the work evolution in progress and felt a high degree of personal responsibility for the situation. The system manager believed the extenuating circumstances of the situation required immediate action, therefore, he climbed on a rigging scaffold and closed the valve. The system manager was totally focused on isolating the leak and failed to consider the radiological work requirements concerning high radiation area entry, access above 7 feet, and industrial safety practices.

### Corrective Steps that have been taken and the Results Achieved

The system manager was prohibited from working in radiologically controlled areas until the incident was investigated and resolved. Operations and HP management were notified of the event and an investigation was initiated. The NRC was promptly notified of the incident.

An appropriate level of discipline was taken against the individual.

This event was discussed at the Engineering All Hands Meeting conducted November 2, 1993.

A letter was issued from the Site Vice President to site personnel regarding compliance with nuclear plant rules. In addition, a memorandum was issued by the Plant Manager describing possible NRC enforcement action against any individual who willfully violates NRC regulations and license conditions.

A Step Up Plan to improve station performance was adopted by senior management and was in early stages of implementation at the time of the event. Management initiatives within this plan include:

- \* Establishment of clear performance expectations
- \* Increased performance monitoring by supervision
- \* Increased emphasis on personnel accountability
- \* Positive reinforcement for good performance
- \* Negative consequences for poor performance

### Corrective Steps That Will Be Taken to Avoid Further Violations

First line supervisors will discuss this event and nuclear plant rules with members of their work groups. These actions will be completed February 28, 1994.

### Date when Full Compliance was Achieved

Full compliance was achieved October 28, 1993, when the system manager exited the high radiation area.

### Reason for the Violation (Example 3)

On October 29, 1993, an engineer was briefed by HP technicians on Unit 3 drywell RWP requirements to walkdown insulation and take pictures of various Residual Heat Removal (RHR) system testable check equalizer valves. The engineer was given instructions not to enter a roped off and posted respiratory protection required area around one of the valves he needed to photograph until actual airborne contamination levels could be determined. After attempting to take photographs of the valve from outside the posted area, the engineer attempted to determine if the air sample results had been evaluated in the hope that the respiratory restrictions near the valve could be removed. The engineer came out of the drywell, but remained in the controlled area. The engineer then attempted to get the attention of the drywell control point HP to question if the air sample results had been evaluated. The drywell control point HP was briefing other workers and did not notice the engineer. The engineer then returned to the area and rationalized that the radiological risks were minimal and that any potential adverse consequences of his actions would not be severe. The engineer then entered a posted respiratory protection required area without required protection or approval to accomplish his task.

### Corrective Steps That Have Been Taken and The Results Achieved

The engineer was prohibited from working in radiologically controlled areas until the incident was investigated and resolved. Engineering and HP management were notified of the event and an investigation was initiated. The NRC was promptly notified of the incident.

The Site Vice President discussed this incident at the October 30, 1993, Outage Senior Management Meeting. He emphasized that the attendees should clearly communicate that this event, coupled with the recent similar events, were absolute infractions of site management expectations.

The Director of Engineering addressed the Site Engineering All Hands Meeting on November 2, 1993, and re-emphasized management expectations concerning worker performance. The engineer involved in this event addressed the group to provide the lessons learned from his actions. Other related events were discussed to enhance the knowledge of engineering personnel concerning proper work practices.

An appropriate and significant level of disciplinary action was taken against the individual.

A letter was issued from the Site Vice President to site personnel regarding compliance with nuclear plant rules. In addition, a memorandum was issued by the Plant Manager describing possible NRC enforcement action against any individual who willfully violates NRC regulations and license conditions.

A Step Up Plan to improve station performance was adopted by senior management and was in early stages of implementation at the time of the event. Management initiatives within this plan include:

- \* Establishment of clear performance expectations
- \* Increased performance monitoring by supervision
- \* Increased emphasis on personnel accountability
- \* Positive reinforcement for good performance
- \* Negative consequences for poor performance



Corrective Steps that will be Taken to Avoid Further Violations

First line supervisors will discuss this event and nuclear plant rules with members of their work groups. These actions will be completed by February 28, 1994.

Date When Full Compliance was Achieved

Full compliance was achieved October 30, 1993, when the engineer was made to exit the respiratory protection required area.