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U.S. NUCLEAR REGULATORY COMMISSION
 OFFICE OF INSPECTION AND ENFORCEMENT

Region I

Report No. 50-277/82-21
50-278/82-20
 50-277
 Jocket No. 50-278
 DPR-44
 License No. DPR-56 Priority _____ Category C
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Licensee: Philadelphia Electric Company
2301 Market Street
Philadelphia, Pennsylvania

Facility Name: Peach Bottom Atomic Power Station, Units 2 and 3

Inspection at: Delta, Pennsylvania

Inspection conducted: September 16 - October 20, 1982

Inspectors: *A. R. Blough* 10/21/82
 A. R. Blough, Senior Resident Inspector date signed

J. C. Linville 11/2/82
 James C. Linville, Senior Resident Inspector (Fitzpatrick) (September 20-24) date signed

D. Johnson 10/28/82
 Donald Johnson, Project Engineer, DPRP (September 28 - October 1) date signed

Approved by: *E. C. McCabe, Jr.* 11/2/82
 E. C. McCabe, Jr., Chief, Reactor Projects Section No. 2B, DPRP date signed

Inspection Summary:

September 16 - October 20, 1982 (Combined Inspection Report 50-277/82-21 and 50-278/82-20)

Routine, on-site and backshift resident inspection (73 hours Unit 2; 68 hours Unit 3) of: accessible portions of Unit 2 and Unit 3, operational safety, control room activities, equipment control, fire protection, licensee events, surveillance testing, maintenance, radiation protection, radioactive waste shipping, physical security (including review of allegations), periodic and special reports, and outstanding items.

Results: Violations: Three (failure to follow locked valve procedures, Detail 3; failure to comply with Radiation Work Permit requirements, Detail 6; and failure to follow fire watch procedures, two examples, Detail 10).

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DETAILS

1. Persons Contacted

W. H. Alden, Engineer-in-Charge, Nuclear Section
B. Clark, Senior Engineer, Nuclear Section
M. J. Cooney, Superintendent, Generation Division (Nuclear)
J. K. Davenport, Maintenance Engineer
G. F. Dawson, I&C Engineer
*R. S. Fleischmann, Assistant Station Superintendent
N. Gazda, Health Physics
A. Hilsmeier, Senior Health Physicist
J. Mitman, Results Engineer
F. W. Polaski, Reactor Engineer
S. R. Roberts, Operations Engineer
D. C. Smith, Outage Manager
S. A. Spitko, Site Q. A. Engineer
S. Q. Tharpe, Security Supervisor
W. E. Tilton, Refuel Floor Supervisor
*W. T. Ullrich, Station Superintendent
A. J. Wasong, Test Engineer
J. E. Winzenried, Technical Engineer

Other licensee employees were also contacted.

*Present at exit interviews on site and for summation of preliminary inspection findings.

2. Previous Inspection Item Update

(Closed) Unresolved Item (277/80-01-01), review low readings on four main steam line temperature sensors (LER 2-79-54/3L) relative to common mode failure potential. The inspector reviewed main steam line temperature sensor arrangement and logic. Sixteen temperature sensors are arranged into four instrument channels. There is one sensor from each channel at each of four locations along the steam line. Each channel has its own power supply. In the LER of concern, the channel 'B' power supply output voltage dropped and caused each of the four channel 'B' sensors to read low. Although this caused an inoperable sensor at four locations, a redundant (channel 'D') sensor was operable at each location. The inspector had no further questions.

(Closed) Violation (78-16-01 and 78-20-01), failure to follow procedure ST/EP-39, First Aid Drill. The licensee has revised ST/EP-39, Revision 6, January 14, 1980, First Aid Drill, to permit substitution involving actual injuries in lieu of simulated. In addition, the revised procedure provides for adequate documentation and review of both actual and simulated injuries.

(Closed) Inspector Follow Item (278/82-03-07), table of bonnet nut torque values in HPCI valve maintenance procedure was incomplete. The inspector reviewed M23.18, Revision 1, April 16, 1982, HPCI Gate Valve Maintenance, and verified that torque tables had been expanded.

(Closed) Violation (278/82-06-04), inadequate transfer of information regarding restrictions of reactor parameters during maintenance or special evolutions. The inspector reviewed Administrative Procedure A-7, Revision 18, June 1, 1982, Shift Operations, and verified that shift turnover checklists have been revised to include reactor parameter restrictions and reasons.

(Closed) Inspector Follow Item (278/82-18-01), guidance on monitoring of core power and thermal limits. The inspector reviewed a memo from the Operations Engineer to licensed shift operators, dated September 24, 1982, and had no further questions on this matter.

(Closed) Inspector Follow Items (277/79-30-07, 278/79-33-07, 277/80-35-06, 278/80-28-02), review followup of Emergency Plan drills. The licensee has revised his Emergency Plan. The NRC has conducted a comprehensive Emergency Plan Appraisal (reference combined report 277/81-28 and 278/81-31) and observed a full-scale Emergency Plan drill (reference combined report 277/82-12 and 278/82-12). The inspector reviewed these reports and determined that the objectives of the previous inspector follow items were met; therefore, these items are closed.

(Closed) Inspector Follow Item (277/79-02-02 and 278/79-02-02), errors in radioactive release tables of Annual Operating Report. The inspector verified that Annual Operating Report No. 2, January 1 - December 31, 1977, had been appropriately revised.

(Closed) Inspector Follow Item (277/79-02-09 and 278/79-02-09), format of main steam line radiation monitor test made it susceptible to recording errors. The inspector verified that the surveillance procedure--ST 4.6, Revision 9, September 17, 1980, Main Steam Line Monitor Functional and Calibration Test, now provides tables consistent with the order in which the channels are checked. The inspector had no further questions.

(Closed) Inspector Follow Item (277/82-19-02), additional snubber data needed in IE Bulletin 81-01 response. The inspector reviewed the licensee's supplemental response, dated October 4, 1982, and verified the overall completeness of the licensee's responses. The inspector had no further questions.

(Closed) Violation (278/77-28-06), failure to retain records for air lock test. The inspector reviewed the licensee's processing and retention system for completed tests. Documentation for two completed tests selected at random by the inspector was promptly retrieved by the licensee. The inspector had no further questions on this item.

3. Plant Operations Review

3.1. Logs and Records

The inspector spot-checked logs and records for accuracy, completeness, abnormal conditions, significant operating changes and trends, required entries, operating and night order propriety, correct equipment and lock-out status, jumper log validity, conformance to Limiting Conditions for Operations, and proper reporting. The following logs and records were reviewed.

- (a) Shift Supervision Log, September 16 - October 20, 1982
- (b) Reactor Engineering Log, Unit 2 - September 16 - October 20, 1982
- (c) Reactor Engineering Log, Unit 3 - September 16 - October 20, 1982
- (d) Reactor Operators Log, Unit 2 - September 16 - October 20, 1982
- (e) Reactor Operators Log, Unit 3 - September 16 - October 20, 1982
- (f) CO Log Book - September 16 - October 20, 1982
- (g) STA Log Book - (Sampling), September 16 - October 20, 1982
- (h) Night Orders - Current Entries
- (i) Radiation Work Permits (RWP's) - Various in both Units 2 and 3, September - October 1982
- (j) Maintenance Request Forms (MRF's) - Units 2 and 3, (Sampling) September - October 1982
- (k) Ignition Source Control Checklists (Sampling) - September - October 1982
- (l) Operation Work & Information Data - September - October 1982

Control room logs were evaluated against Administrative Procedure A-7, "Shift Operations." Frequent initialing of entries by licensed operators, shift supervision, and licensee on-site management constituted evidence of licensee review.

No unacceptable conditions were identified.

3.2 Facility Tours

Daily tours and observations included the following:

- Control Room - (daily).
- Turbine Building - (all levels).
- Reactor Building - (accessible areas).
- Diesel Generator Building.
- Yard area perimeter exterior to the power block, including Emergency Cooling Tower and torus dewatering tank.
- Security Building, including CAS, Aux SAS, and control point monitoring.
- Vehicular Control.
- The SAS and power block control points.
- Security Fencing.
- Portal Monitoring.
- Personnel and Badging.
- Control of Radiation and High Radiation areas, including locked door checks.
- TV monitoring capabilities.
- Shift turnover.

3.2.1 Control Room Manning. Staffing frequently was checked against 10 CFR 50.54(k), the Technical Specifications, and commitments to the NRR letter of July 31, 1980. Presence of a senior licensed operator in the control room complex was verified frequently. No unacceptable conditions were identified.

3.2.2 Fluid Leaks. The inspector observed sump status, alarms, and pump-out rates, and discussed leakage with licensee personnel. No violations were identified.

3.2.3 Piping Vibration. No significant or unusual piping vibration was identified.

- 3.2.4 Monitoring Instrumentation. The inspector frequently confirmed that selected instruments were operating and indicated values were within Technical Specification requirements. Daily, when the inspector was on site, ECCS switch positioning and valve lineups, based on control room indicators and plant observations were verified. Observations included flow setpoints, breaker positioning, PCIS status, radiation monitoring instruments, and process computer printouts. Selected engineered safety feature actuation instrument readouts were checked for consistency with plant conditions. No violations were identified.
- 3.2.5 Environmental Controls. The inspector observed visible portions of main stack and ventilation stack radiation recorders and periodically reviewed traces from backshift periods to verify that radioactive gas release rates were within limits and that unplanned releases had not occurred. The inspector reviewed licensee samples and administrative controls for the following planned liquid release to verify that regulatory requirements were met:

<u>Radwaste No.</u>	<u>Source</u>	<u>Release Date</u>
1446-82	Floor Drain Sample Tank	September 17

From September 22 through the end of the inspection, there were no releases of liquid radwaste. No violations were identified.

- 3.2.6 Fire Protection. On frequent occasions the inspector verified the licensee's measures for fire protection. The inspector observed control room indications of fire detection and fire suppression systems, spot-checked for proper use of fire watches and ignition source controls, checked a sampling of fire barriers for integrity, and observed fire-fighting equipment stations. No violations were identified.
- 3.2.7 Equipment Conditions. The inspector verified operability of selected safety equipment by in-plant checks of valve positioning, control of locked valves, power supply availability and breaker positioning. Selected major components were visually inspected for leakage, proper lubrication, cooling water supply, operating air supply, and general conditions. Systems checked included Unit 3 HPCI and RCIC, Unit 2 'B' and 'D' RHR, and Unit 2 'A', 'C' and 'D' Core Spray. While touring the Unit 2 'B' RHR room on September 22, 1982, the inspector noted a misaligned mounting clamp on hydraulic snubber 10-GB-S-48. When informed, the licensee checked the snubber and determined it was operable in the existing configuration, but also promptly realigned the mounting clamp as required by procedures. The inspector had no further questions on this item.

Selected Emergency Service Water System valves and safety instrument root valves were also checked. At safety-related instrument racks in the Unit 2 Reactor Building 165-foot elevation, the inspector noted the following discrepancies:

- (1) several valves were missing hand-wheels,
- (2) several valve hand-wheels were not color-coded (the licensee color-codes these valves according to normal position), and
- (3) several rack isolation valve hand-wheels had incorrect color-coding.

On October 15, the inspector identified similar problems at the corresponding Unit 3 instrument racks. Additionally, the inspector identified a case where an instrument had been removed by a modification, its sensing lines had been terminated by test caps, color-coding of the two rack isolation valves had not been changed, and the valves were open. Thus, the test caps were unnecessarily subjected to reactor pressure. The licensee subsequently identified four other unnecessarily pressurized test caps. All associated isolation valves were promptly shut. Although the licensee is not committed to color-coding of instrument valve hand-wheels, the presence of improper color-coding is of safety concern, because it provides a misleading indicator of normal valve position. The licensee stated that instrument rack maintenance would be upgraded and began work on October 16 during backshifts. On October 18 the inspector noted some progress. The issue of instrument rack maintenance is unresolved pending further review, including follow-up of licensee corrective measures (277/82-21-01 and 278/82-20-01).

About 10:00 a.m. September 21, the inspector noted that ESW Valve 519C, Inlet to the 'C' Diesel, was open (as required) but not locked. A lock and chain were attached to the valve yoke but did not engage the hand-wheel. Administrative Procedure A-8, Revision 4, January 22, 1980, Procedure for Control of Locked Valves, requires valves listed on its appendices to be locked unless operations or maintenance in progress requires otherwise. ESW inlet valves to the diesels are listed on Appendix A-8C, Revision 6, April 1, 1982. No related operations or maintenance were in progress. Failure to maintain valves locked as required violates Technical Specification 6.8 and Regulatory Guide 1.33 (November 1972), which require implementation of procedures for equipment control (277/82-21-02 and 278/82-20-02). When informed, the licensee locked the valve. He was not able to determine when or why the valve hand-wheel had been unlocked. The licensee re-checked all valves on Locked Valve Lists A-8B (Unit 3) and A-8C (Common

Equipment). Valves on Appendix A-8A (Unit 2) had been checked on September 14 following discovery of mis-positioned Unit 2 Service Air drywell isolation valves (reference combined report 277/82-19 and 278/82-18). The licensee indicated that additional corrective measures regarding equipment control were being considered. The inspector stated that this Violation is recurrent in that a similar violation occurred in April 1982 (reference combined report 277/82-06 and 278/82-06).

The inspector reviewed selected blocking permits (tagouts) for conformance to licensee procedures. Breaker and switch positioning was verified for permit 2-13M2-38, Unit 2 RCIC (Ground Control Circuit); no discrepancies were noted.

3.3 Follow-up of Events Occurring During the Inspection--Unplanned Release of Radioactive Liquid

On September 17, 1982, an unplanned release of radioactive liquid from the Recombiner Building to the storm drain system occurred from about 10 a.m. to 11:30 a.m. The Recombiner Building ventilation filter fire suppression (sprinkler) system had activated inadvertently, and suppression water flowed across contaminated areas into the (contaminated) drain sump. Because the sprinkler rate exceeded sump pump capacity, the sump overflowed onto the building floor, under a door and into an outside storm drain. About 200 gallons were released. Licensee personnel stopped the release by isolating the sprinkler header and sealing the door. A sample of water flowing into the storm drain system indicated about $1.8E-5$ microcuries per milliliter of Cesium-137, about 89 per cent of Maximum Permissible Concentration (MPC) for unrestricted areas, per 10CFR20, Appendix B, Table II. The first catch basin was contaminated to 17 per cent of MPC. Repeated sampling of subsequent catch basins indicated no detectable activity, indicating significant dilution prior to release to the environment. About 8:00 p.m., September 17, the licensee recovered water from the first (contaminated) catch basin and processed it into the radwaste system. The licensee calculated the total activity released as 13 microcuries. On September 21, 1982, the licensee issued a Licensee Event Report after informing the inspector that, due to an oversight, the report was one day late. In his follow-up report on October 1, 1982 the licensee committed to installing barriers at the Recombiner Building doors by January 1, 1983. The inspector will review these modifications (277/82-21-03).

4. IE Circular 78-19, Manual Override of Safety System Activation Signals

This issue was re-addressed in IE Bulletin 79-08; NRC inspection was completed in report 277/80-35 and 278/80-28. This circular is therefore closed.

5. Surveillance Testing

The inspector observed surveillance to verify that testing had been properly approved by shift supervision, control room operators were knowledgeable regarding testing in progress, approved procedures were being used, redundant

systems or components were available for service as required, test instrumentation was calibrated, work was performed by qualified personnel, and test acceptance criteria were met. Parts of the following tests were observed:

- ST 3.3.1, Revision 13, May 2, 1978, APRM Functional and Calibration Test, performed October 12, 1982 (Unit 2);
- ST 9.16, Revision 12, June 25, 1982, Containment Gross Leak Rate Test Detection, week of October 11, 1982 (Units 2 and 3);
- ST 9.17, Revision 0, January 17, 1976, Reactor Coolant Leakage Test, week of October 11, 1982 (Units 2 and 3);
- ST 1.14B, Revision 0, September 2, 1982, ECCS 'B' Power Supply Ripple, performed October 18, 1982 (Unit 2);
- ST 1.15A, Revision 0, September 2, 1982, RPS 'A' Power Supply Ripple, performed October 18, 1982 (Unit 2); and
- ST 1.15B, Revision 0, September 2, 1982, RPS 'B' Power Supply Ripple, performed October 18, 1982 (Unit 2).

The inspector also checked completed documentation for the following tests:

- ST 20.004, Revision 3, May 3, 1982, LLRT--Personnel Airlock, completed August 15, 1982 and September 12, 1982 (Unit 2);
- ST 7.1.1, Revision 8, January 3, 1980, Standby Liquid Control Tank Boron Concentration, performed as follows:
 - (1) September 30, 1982, Unit 2, monthly test;
 - (2) September 30, 1982, Unit 2, after water addition;
 - (3) October 6, 1982, Unit 3, monthly test; and
 - (4) October 7, 1982, Unit 3, after boron addition.

No violations were identified.

6. Radiation Protection

During this report period, the inspector examined work in progress in both units, including the following:

- a. Health Physics (HP) controls
- b. Badging

- c. Protective clothing use
- d. Adherence to RWP requirements
- e. Surveys
- f. Handling of potentially contaminated equipment and materials

More than 40 people observed and enforcing requirements of Health Physics procedures. A sampling of high radiation doors was verified to be locked as required.

While in the Unit 2 'A' Core Spray Room about 2:45 p.m. on October 12, 1982, the inspector observed two workers exiting the Torus Room. Neither of the workers nor their fire watch (who had remained in the Torus Room) had an alarming dosimeter as required by the applicable RWP, 2-94-0624, September 18, 1982, Unit 2 Torus Room MOD 651. The workers had been in the Torus Room since about 1:10 p.m. Technical Specification 6.11, Radiation Protection Program, requires adherence to radiation protection procedures for all operations involving personal radiation exposure. Procedure HPO/CO-4, Revision 17, December 18, 1981, Radiation Work Permits, requires personnel to comply with the applicable RWP. Failure to do so is a Violation (277/82-21-04). When informed, the licensee immediately sent a Health Physics technician to the area to verify that the fire watch had also exited. The licensee formally investigated the event. The workers involved were disciplined, and the event was critiqued with the entire work group (Mechanical Construction Division) prior to the next work day. Actual radiation levels in the work area were 5 to 20 milliroentgen per hour; however, high radiation existed elsewhere in the Torus Room. Exposures to individuals were 10 millirem or less for the day. For subsequent work, the licensee revised the RWP to allow use of either an alarming dosimeter or a continuously indicating rate-meter. The licensee is committed (by letter, S. L. Daltroff to R. C. Haynes, dated August 16, 1982) to an on-going program to improve worker adherence to Health Physics requirements. Based on the specific corrective actions for this event and the licensee's on-going program, the inspector had no further questions.

7. Review of Licensee Event Reports (LERs)

7.1 In-office Review

The inspector reviewed LERs submitted to NRC:RI to verify that the details were clearly reported, including the accuracy of the description and corrective action adequacy. The inspector determined whether further information was required, whether generic implications were indicated, and whether the event warranted onsite followup. The following LERs were reviewed:

<u>LER No./</u> <u>LER Date/</u> <u>Event Date</u>	<u>Subject</u>
*2-79-26/1P May 24, 1979 May 24, 1979	Off-gas stack radiation monitor sample system inoperable for about 9 hours.
2-81-41/3L October 22, 1981 September 23, 1981	During ST, HPCI gland seal condenser developed a gasket leak; gasket was replaced; redundant equipment was operable.
2-81-42/3L November 20, 1981 October 21, 1981	HPCI gland seal condenser had gasket leak; gasket was replaced. Later a gasket retaining band was placed around the flange per vendor recommendations. Redundant equipment was operable.
2-81-30/3L September 25, 1981 August 16, 1981	Leak discovered in E-4 Diesel Generator Cooling Jacket; other diesels were operable during repairs.
2-81-36/3L September 2, 1981 August 4, 1981	Oxygen analyzer isolation valve failed to close during surveillance testing; in-line valve was kept closed during repairs.
*2-82-30/1P and 1T October 1, 1982 (1T) September 17, 1982	Unplanned liquid release from Recombiner Building to storm drains (undetectable at site boundary).
2-82-25/3L September 24, 1982 August 27, 1982	One 'C' RHR Room cooling fan failed to start during test; redundant fan was operable during repairs.
2-82-26/3L September 30, 1982 August 31, 1982	RHR pump breaker closing spring failed to charge after test; breaker was replaced.

7.2 On-site Followup

For LERs selected for onsite review (denoted by asterisks above), the inspector verified that appropriate corrective action was taken or responsibility assigned and that continued operation of the facility was conducted in accordance with Technical Specifications and did not constitute an unreviewed safety question as defined in 10CFR50.59. Report accuracy, compliance with current reporting requirements and applicability to other site systems and components were also reviewed.

-- LER 2-79-26/1P. This event was caused by lack of prompt attention to annunciated alarms. The inspector discussed alarm conditions with operators and observed operator responses. The inspector also noted that the number of lit annunciators in the control room has been reduced by a factor of about three since this event. Therefore, the inspector had no further questions on this event.

-- LER 2-82-30/1P and 1T. See Detail 3.3.

8. Maintenance

The inspector observed portions of Unit 2 125-VDC Battery maintenance, Maintenance Request 2-57-M2-51, in progress on September 20, 1982. Proper administrative controls were also verified. For other selected maintenance activities, the inspector verified that redundant equipment was available and had been tested as required and spot-checked that administrative controls, including maintenance requests, blocking permits (tagouts) and shift turnover information; were being implemented.

No violations were identified.

9. Radioactive Waste Shipment

On September 23, 1982, the inspector observed the preparation of Radioactive Waste Shipments 259-82 and 260-82 per procedure HPO/CO-71C, Appendix A, Revision 5, June 17, 1982, Loading and Closing the HN-100, Series 2, Radioactive Waste Shipping Cask. Observations included loading operations, radiation surveys, quality control inspections, and documentation review. During transfer of high integrity cask (HIC) 2761, which read 2 Roentgens per hour on contact, from the Radwaste Building to a pallet on the trailer, a cotter pin on the manipulator arm mechanism failed; causing the HIC to drop about four feet to the ground. Licensee personnel took prompt action to isolate the area around the HIC, conduct surveys, and inspect the drum for damage. Since the HIC did not appear to be damaged, licensee personnel picked it up and placed it on the pallet, using a crane and a nylon lifting sling. After making a temporary repair to the manipulator using a hairpin about the same size as the cotter pin, the licensee moved HIC 2761 from the pallet back to the Radwaste Building. During transfer, the HIC was held in the air for several minutes by the manipulator while storage space was cleared. The licensee then terminated use of the manipulator pending permanent repair and testing. The partially loaded pallet containing five of its seven HIC capacity was placed into the cask. The pallet was subsequently removed from the cask and two LSA drums were added via forklift truck to complete the load prior to shipment.

During response to this event, the licensee deviated from procedures in two instances without documenting temporary procedure changes. However, the actions taken were technically adequate and experienced engineers, supervisors and technicians were present. The inspector considers the failure to authorize temporary procedure changes an isolated case. The inspector discussed this event with the licensee and pointed out that since the HIC was not damaged, no emergency existed. Further, a more

methodical approach to recovery could have resulted in avoiding leaving the HIC suspended for several minutes while supported by the temporarily-repaired, untested manipulator. The licensee acknowledged these statements and stated that temporary procedure change requirements would be stressed to operations personnel. The inspector had no further questions on the item.

10. Physical Security

10.1 Routine Operations

The inspector spot-checked compliance with the accepted Security Plan and implementing procedures, including: operations of the CAS and SAS, over 20 spot-checks of vehicles onsite to verify proper control, observation of protected area access control and badging procedures on each shift, inspection of physical barriers, checks on control of vital area access and escort procedures. No violations were identified.

10.2 Security Force Manning

NRC Region I received allegations regarding security force manning during diesel generator maintenance in late July 1982. It was alleged that guards had been used as fire watches, reducing the number of available armed responders to less than required by the Accepted Security Plan. The inspector reviewed the following documents:

- Fire Watch Status Sheets, July 9 - August 9, 1982;
- Procedure A-12, Revision 3, October 16, 1981, Appendix A, Ignition Source Control Checklist, completed copy for diesel generator maintenance, July 22, 1982;
- Procedure A-12.1, Revision 3, April 23, 1982, Procedure for Controlling Technical Specification Fire Watch and Fire Watch Patrols;
- A-12.1, Appendix A, Fire Watch Instructions, completed copies of diesel generator maintenance, July 20-24, 1982;
- Security Log Book, July 1982;
- Guard Sign-in sheets, July 1982;
- Weapons Sign-out sheets, July 1982;
- Completed Guard Rosters (shift watch station assignments), July 1982; and
- Selected licensee Security Procedures.

The inspector also interviewed the Security Supervisor, the Captain of the Guard Force, sergeants (shift supervisors), and armed guards.

- 10.2.1 Procedure A-12.1 governs the posting of continuous fire watches per Technical Specifications, including during inoperability of a fire barrier protecting the Cable Spreading Room. The procedure states that a fire watch shall have no other duties and requires in part, completion of a fire watch instruction sheet, which is specific to the job and provided to the fire watch. Also, logging of equipment status on the Fire System Status Sheet is required. The Technical Specification required fire

watch posted July 24-26 had concurrent duties as a member of the minimum armed response force required to be available at all times to respond to a security alert. He was not provided with an instruction sheet nor was the appropriate information recorded on the Fire System Status Sheet. Technical Specification 6.8 and Regulatory Guide 1.33 (November 1972) require implementation of written procedures for the fire protection system. Failure to implement procedures for controlling a fire watch is a Violation (277/82-21-06 and 278/82-20-04).

- 10.2.2 The inspector noted that procedures PP-3 and PP-16 were out-of-date regarding security patrols and posts. A licensee audit had identified similar problems and the procedures were being revised. The inspector verified that the out-of-date procedures were not resulting in violation of Security Plan requirements.

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11. In-Office Review of Periodic and Special Reports

11.1 Monthly Operating Report

Peach Bottom Atomic Power Station Monthly Operating Report for August 1982, dated September 13, 1982, was reviewed pursuant to Technical Specifications and verified to determine that operation statistics had been accurately reported and that narrative summaries of the month's operating experience were contained therein. No unacceptable conditions were identified.

11.2 Thermal Mapping Reports

Isotherm surveys of the Conowingo Pond section of the Susquehanna River are required by Environmental Technical Specifications when river flow is less than 15,000 cubic feet per second and less than three cooling towers are operating. The inspector reviewed the following Thermal Mapping Reports:

<u>Report No. & Date</u>	<u>Survey Date</u>
81-1/September 3, 1982	August 3, 1982
82-2/September 10, 1982	August 11, 1982
82-3/September 28, 1982	August 18, 1982
82-4/October 8, 1982	September 9, 1982

No violations were identified.

12. Unresolved Items

Unresolved items are items about which more information is required to ascertain whether they are acceptable, violations, or deviations. Unresolved items are discussed in Details 3 and 10.

13. Management Meetings

13.1 Preliminary Inspection Findings

A summary of preliminary findings was provided to the Station Superintendent at the conclusion of the inspection. During inspection, licensee management was periodically notified of the preliminary findings by the resident inspector. The dates involved, the senior licensee representative contacted, and subjects discussed were as follows:

<u>Date</u>	<u>Subject</u>	<u>Senior Licensee Representative Present</u>
September 17	Routine Discussions	Station Superintendent

September 24	Routine Discussions, Radioactive Waste Shipping, Locked Valve Control	Station Superintendent
October 1	Routine Discussions, Previous Inspection Item Follow-up	Station Superintendent
October 7	Security Force Manning	Security Supervisor
October 7	Routine Discussions Security Force Manning, Firewatch Procedures	Station Superintendent
October 8	Locked Valve Controls, Firewatch Procedures, Radioactive Waste Shipping	Operations Engineer
October 12	RWP Adherence	Senior Health Physicist
October 13	Instrument Valves	Technical Engineer
October 14	Security Force Manning	Assistant Station Super- intendent
October 15	Routine Discussions, Instrument Valve Main- tenance, Physical Security	Station Superintendent
October 21	Summary of Preliminary Findings	Station Superintendent

13.2 Attendance at Management Meetings Conducted by Region-Based Inspectors

The resident inspector attended entrance and exit interviews by region-based inspectors as follows:

<u>Date</u>	<u>Subject</u>	<u>Inspection Report No.</u>	<u>Reporting Inspector</u>
October 18 (Entrance)	Physical Security	277/82-22 278/82-21	J. Dunlap