

U. S. NUCLEAR REGULATORY COMMISSION

REGION I

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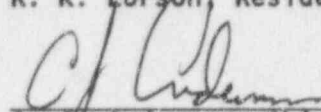
Licensee: PECO Energy Company
P. O. Box 195
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Facility Name: Peach Bottom Atomic Power Station Units 2 and 3

Dates: June 25 - August 12, 1995

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Approved By:



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8/28/95
Date

EXECUTIVE SUMMARY
Peach Bottom Atomic Power Station
Inspection Report 95-15

Overall Assurance of Quality:

Shift management demonstrated excellent command and control, questioning attitude, and attention-to-detail while performing an operability determination for the E-1 emergency diesel generator (EDG) following the discovery of a faulty fuel injector pump on the number 12 cylinder (Section 2.3) and when the Unit 3 high pressure coolant injection (HPCI) steam admission valve (MO-14) failed to fully open during a surveillance test (Section 3.1).

The Independent Safety Engineering Group demonstrated an excellent performance by identifying two potentially significant issues. These issues involved a minor unmonitored release of radioactive condensate to the discharge canal and the reliability of an EDG ventilation supply fan (Section 4.2).

Plant Operations:

PECO operated both units safely over the period. Unit 2 operators performed routine activities well over the entire period. Unit 3 operators responded well to an automatic reactor scram, which followed a main turbine trip on a high reactor water level condition (Section 2.2).

Shift management displayed a timely response by declaring an Unusual Event when a potentially contaminated man was transported off-site (Section 2.1)

The inspectors closed two unresolved items for the low pressure coolant injection stayfill accumulator not full (URI 95-04-01) and the interpretation of non-action verification steps (URI 94-04-02)(Sections 2.4 and 2.5).

Maintenance and Surveillance:

Maintenance technicians performed observed maintenance activities well. These included the rebuild of the Unit 2 standby liquid control pump (Section 3.2) and the replacement of the failed Unit 3 HPCI steam admission valve (MO-14) motor (Section 3.1). The inspector observed the failed motor disassembly and failure investigation and noted that the personnel performing the investigation were knowledgeable and thorough.

The inspector found that PECO nuclear maintenance division personnel performed the handling, inspection, channeling, and placing of the new fuel into the fuel pool in a professional and well coordinated manner (Section 3.3).

The inspectors closed two unresolved items for the verification of "Q" fuses in single cell battery chargers (URI 94-27-02) and the standby liquid control system in-service testing (URI 95-04-03)(Sections 3.4 and 3.5).

(EXECUTIVE SUMMARY CONTINUED)

Engineering and Technical Support:

The inspector determined that PECO's actions were appropriate following a loss of electrical power to the technical support center during the restoration from a lighting strike to an off-site power line (Section 4.1).

The inspectors closed several unresolved items for HPCI output current converter electromagnetic interference (URI 94-08-03), diesel cooling system valve testing (URI 94-13-03), steam/water discharge to the reactor building during reactor water cleanup system testing (NCV 94-27-03), and inadequate control of temporary shielding (NOV 95-01-01)(Sections 4.3, 4.4, 4.5, and 4.6).

Plant Support:

The inspectors observed the 1995 Annual Emergency Exercise and concluded that PECO responded excellently to the simulated plant challenges (Section 5.3). During this exercise, the inspector observed activities in the operations support center (OSC) and closed an open item dealing with the control of repair teams (IFI 94-20-01).

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DETAILS

1.0 PLANT ACTIVITIES REVIEW

1.1 PECO Energy Company Activities

The PECO Energy Company (PECO) safely operated Peach Bottom Atomic Power Station (PBAPS) Unit 2 (Unit 2) and Unit 3 (Unit 3) over the period.

Unit 2 operated at essentially 100% power for the entire period. A scheduled load drop to about 35% power occurred on August 12, to perform control rod scram time testing and rod pattern adjustments. The inspection period ended during this evolution.

Unit 3 began the inspection period operating at about 79% power, due to end-of-cycle coastdown. Power operation continued until July 30, when the unit automatically scrammed on high reactor water level due to a control signal failure for the 3A reactor feed pump (RFP)(Section 2.1). PECO restarted the unit on August 1 and ended the inspection period operating the unit at about 70% power.

The E-1 emergency diesel generator (EDG) became inoperable on July 1, as a result of a leaking fuel injection pump (Section 2.2). Repairs were completed and the EDG was made operable later the same day. The E-2 EDG became inoperable on July 18, after an operator identified an abnormal noise and a leak in the jacket water cooling system. PECO determined the noise to be from a failed exhaust gasket. The E-2 EDG was returned to service on July 19 following repairs. On July 26, the output breaker for the E-3 EDG opened unexpectedly during a surveillance test. PECO declared the E-3 EDG inoperable and determined that a motor-operated potentiometer in the voltage regulator had failed. The potentiometer, which is controlling when the EDG is operating in the parallel mode, would not have affected the E-3 EDG performance during emergency operation due to the machine operating in the isochronous mode. PECO performed appropriate repairs and returned the EDG to an operable status on July 27. The inspectors determined the safety significance of these events to be low since they occurred during surveillance testing and did not represent possible generic concerns.

1.2 NRC Activities

The resident and region based inspectors conducted routine and reactive inspection activities in several areas including: operations (Section 2.0); surveillance and maintenance (Section 3.0); engineering and technical support (Section 4.0); and plant support (Section 5.0).

The following specialist inspections also occurred during the report period:

<u>Date</u>	<u>Subject</u>	<u>Report No.</u>	<u>Inspector</u>
7/10-14/95	Engineering	95-18	Lohmeier
7/17-21/95	Self Assessment	95-80	Evans

2.0 PLANT OPERATIONS REVIEW (71707, 92901, 93702)¹

The inspectors observed that operators conducted routine Unit 2 activities well, including surveillance testing, minor reactor power adjustments, and minor troubleshooting activities. The Unit 3 control room operators also conducted routine operations well, responding well to an automatic reactor scram on high water level (Section 2.1), and to a high pressure coolant injection system (HPCI) steam admission valve failure (MO-14) (Section 4.1).

The operations crews made correct determinations of safety system operability and reportability of identified conditions. The crews adequately tracked and controlled entry into and exit from technical specification (TS) limiting conditions for operation (LCOs). The inspectors routinely verified the operability of safety systems required to support plant conditions at both units and did not identify any concerns. Housekeeping at both units was good.

2.1 Unusual Event - Unit 3

PECO demonstrated a timely response by declaring an Unusual Event for a potentially contaminated injured man being transported off-site by ambulance at 10:25 a.m., on August 9. The injured man, a PECO maintenance employee, fell from the top of the Unit 3 torus, on the inboard side, to the reactor pedestal injuring his leg at 10:11 a.m. PECO was unable to complete their survey of the man prior to transporting him to an off-site medical facility and declared the event. PECO informed the NRC of the event at 10:35 a.m. and terminated the event at 11:58 a.m.

The man had been performing local leak rate testing (LLRT) for containment atmosphere control valves and was not wearing a safety harness when he fell. Health Physic (HP) technicians were unable to survey the man's back as the Medical Response Team transported him on a body board; therefore, PECO was unable to positively determine if the man was contaminated. Two HP technicians accompanied the injured man to Hartford County Hospital. After arriving at the hospital, the HP technicians surveyed the man and found trace amounts of contamination on the man's clothing, but no contamination on the man. These articles of clothing were properly contained.

As a corrective action, PECO stopped further LLRT work in the torus area in order to critique the event and to emphasize management expectations for personnel safety to the craft. The inspector reviewed PECO's activities related to this event and found them to be satisfactory.

¹The inspection procedure from NRC Manual Chapter 2515 that the inspectors used as guidance is parenthetically listed for each report section.

2.2 Automatic Reactor Scram and Forced Outage - Unit 3

PECO responded well on July 30 to an automatic Unit 3 reactor scram, which followed a main turbine trip on a high reactor water level condition. The high reactor water level condition occurred when the 3A RFP speed increased unexpectedly due to a control signal failure. The other operating RFP (3C) speed automatically decreased as expected, but was unable to compensate for the 3A speed increase. The inspector reviewed the operating log and reactor parameter data and concluded that the operators responded promptly to this event to stabilize plant conditions. All systems responded as expected and there was no automatic initiation of any emergency safeguard systems.

PECO developed a forced outage plan following the unit trip and focused on repair of the 3A RFP, restoration of the 3B RFP (which had been previously removed from service due to the end-of-cycle coastdown), correction of some intermediate range nuclear instrument "spiking" indications, and repair of an inoperable control rod position indication. Prior to the start-up from the forced outage, PECO identified a steam leak from the bonnet of the 3B feedwater check valve (CHK-3-06-96B), which provides a primary containment isolation safety function. PECO quantified the leak rate and determined that the amount of leakage did not render the valve or the primary containment penetration inoperable. PECO also performed a temporary repair of CHK-3-06-96B during the power ascension.

PECO commenced the reactor start-up on July 31, and reached about 71% power on August 4 (power was limited due to the end of cycle coastdown). The inspector observed the beginning of the start-up and power ascension activities, and observed that the activities were well controlled. The inspector concluded that PECO's scram response, forced outage, and start-up activities were well controlled.

2.3 Emergency Diesel Generator Inoperable

On June 30, PECO operators demonstrated excellent command and control while performing an operability determination for the E-1 EDG following the discovery of a faulty fuel injector pump on the number 12 cylinder. An operator discovered the injector problem by noting that the exhaust temperature from the number 12 cylinder was 100°F lower than the other cylinders after running the E-1 EDG for a surveillance test on June 28. PECO determined that this lower temperature did not affect the E-1 EDG's immediate operability, however, the 250°F delta between the highest and lowest cylinder temperatures impacted the EDG's long term reliability. PECO decided to immediately replace the injector pump. The Shift Manager declared the E-1 EDG inoperable and requested site engineering to perform a common mode failure analysis as required by TS 4.9.B.3. to ensure that the other EDGs would not be affected. The analysis concluded that a common mode failure did not exist. PECO replaced the injector pump and declared the E-1 EDG operable on July 1.

The Shift Manager determined that the TSs required the remaining EDG's operability to be demonstrated within 24 hours either by running each EDG or by performing a common mode failure analysis. The Shift Manager rejected the initial engineering response which primarily consisted of a review of

recurring action requests and stated that an engineering review of past operating data was necessary to adequately determine if a common mode failure existed. Site engineering then reviewed the past performance data and concluded that since only one of the injector pumps had failed a common mode failure did not exist.

The inspector discussed with the Shift Manager, his determinations and conclusions, and found them to be well supported. The inspector also reviewed the actions that led to the discovery of the faulty injector. The inspector concluded that PECO's response demonstrated a good command and control, questioning attitude, and attention-to-detail throughout this event.

2.4 (Closed) Unresolved Item 95-04-01 - Low Pressure Coolant Injection Stayfill Accumulator Not Full

PECO satisfactorily evaluated the cause of a mis-positioned breaker that de-energized a solenoid-operated vent (SOV) valve on the 2A low pressure coolant injection (LPCI) stayfill accumulator. Operators had found the breaker open for the "auto-venting" SOV while responding to a low level condition in the LPCI accumulator. The inspector became concerned that the LPCI discharge piping possibility was not completely filled, that the accumulator's level switch had mis-operated and questioned how these problems affected system operability.

PECO had initially declared the 2A LPCI loop inoperable and determined that the line vent accumulator had functioned properly by performing portions of the pump, valve, and flow surveillance test. PECO concluded that the 2A LPCI loop had been inoperable for the duration that the accumulator low level alarm had been in and that the LPCI discharge piping had always been full.

PECO could not positively determine the exact cause for how the SOV supply breaker became open, but concluded that it most likely occurred during the removal of another clearance from the panel. PECO reviewed many clearances and surveillance tests associated with the system for the work week in question and for the prior two weeks. They found that the breaker had not been tagged or manipulated during a surveillance test. They also reviewed clearances that were applied in the associated breaker panel. Although it could not be proven, the most likely scenario as to when the breaker became open was when a clearance in the same panel, in the vicinity of the breaker was released.

The inspector reviewed PECO's activities and the performance enhancement process (PEP) evaluation of this event. He discussed the findings and conclusions with the system manager and was satisfied with PECO's response. This item is closed.

2.5 (Closed) Unresolved Item 94-04-02; Interpretation of Non-Action Verification Steps

This item was opened to allow review of PECO's action to ensure that operators took appropriate steps when a procedure verification step could not be met. In April 1994 the inspector identified a case, where operators, during

surveillance testing had been reclosing a valve when a verification of pressure could not be met. This operator action, not specified by the procedure and not documented, resulted in an untimely identification of a problem with the reclosed valve.

PECO took appropriate action to address the proper use of a verification step in the operation manual. The OM-P-15.1 section 4.11.2, states, in part, that if a verification step can not be completed it must be signed-off as unsatisfactory and in accordance with standard procedural guidance, the procedure should be stopped, equipment placed in a safe condition, and shift management informed. Based on this guidance to the operators, the inspector closed this item.

2.6 Licensee Event Report Update

The inspectors reviewed the following Licensee Event Reports (LERs), finding them factual and that PECO had identified the root causes, implemented appropriate corrective actions, and made the required notifications.

<u>LER No.</u>	<u>LER Date</u>	<u>LER Title</u>
2-95-001	6/10/95	Unplanned Engineered Safety Feature Actuation During Diesel Testing
2-95-002	6/18/95	Condition Prohibited by TS when two EDGs were Inoperable at the same time
3-95-002	7/6/95	High Pressure Coolant Injection System Valve Motor Failure

2.7 10 CFR Part 21 Report Update

The inspectors reviewed the actions taken on several 10 CFR Part 21 reports, and assessed that PECO took proper corrective actions on any reports that applied to PRAPS. The 10 CFR Part 21 reports reviewed are listed in Appendix A.

3.0 MAINTENANCE AND SURVEILLANCE TESTING (61726, 62703, 92902)

The inspectors routinely observed the conduct of maintenance and surveillance tests (STs) on safety related equipment. This involves the review of on going activities to ensure: the proper use of approved procedures and skills of the craft, the calibration of testing instrumentation, the qualification of personnel, and the implemented administrative controls including blocking permits, fire watches, ignition sources, radiological controls, and test acceptance criteria were met. In the maintenance area the inspectors reviewed maintenance procedures, action requests (AR), work orders (WO), and radiation work permits (RWP). During observation of maintenance work, the inspectors verified appropriate Quality Verification (QV) involvement, plant conditions, TS LCOs, equipment alignment and turnover, post-maintenance testing and reportability review.

In the surveillance area the inspector reviewed test procedures and completed tests to verify the adequate demonstration of safety functions. During

surveillance observations, the inspectors verified that tests were properly scheduled and approved by shift supervision prior to performance; control room operators were knowledgeable about testing in progress, and that redundant systems or components were available for service, as required. The inspectors routinely verified adequate performance of daily STs including instrument channel checks and the jet pump and control rod operability tests.

3.1 High Pressure Coolant Injection System Valve Motor Failure - Unit 3

PECO responded well when the Unit 3 HPCI steam admission valve (MO-14) failed to fully open during a surveillance test on July 6. PECO promptly declared the HPCI system inoperable, made the required four-hour event notification to the NRC per 10 CFR 50.72 (b) (iii), and initiated troubleshooting to determine the cause of the failure. PECO subsequently determined that the MO-14 valve motor had failed and initiated an engineering change request (ECR) and work order (WO) to replace the motor.

PECO replaced the failed motor on July 7, with a readily available motor that had similar electrical ratings. The ECR analysis justified the use of the spare motor. The inspector noted that the WO provided adequate guidance for replacing the motor and for performing the post-maintenance testing (PMT). The new motor was successfully tested and HPCI declared operable on July 7.

PECO disassembled the motor and performed a root cause investigation to determine the cause for the failure. The inspector observed the disassembly and investigation noting that the personnel were knowledgeable and thorough. The preliminary investigation findings indicated that the motor failure resulted from stator winding insulation damage, apparently caused by vibrational contact between the winding and other internal motor components during operation. The inspector noted that the damaged winding appeared to have been loosely restrained which would have allowed it to vibrate and determined that PECO's initial analysis was acceptable. The inspector had no additional questions.

3.2 Standby Liquid Control Pump Maintenance - Unit 2

The inspector observed very good on-line maintenance on the 2B standby liquid control (SBLC) pump. The inspector verified that the proper TS LCO controls were in place and that the clearance provide proper mechanical isolation of the area. Maintenance technicians demonstrated excellent skills of the trade during the pump and gear box inspection and cleaning. The inspector noted very good supervisory presence and that the system manager observing the work asked very good questions.

3.3 Refuel Preparation Operations - Unit 3

The inspector found that PECO nuclear maintenance division (NMD) personnel performed the handling, inspection, channeling, and placing of the new fuel into the fuel pool in a professional and well coordinated manner. Observations of the new fuel handling on the Unit 3 refuel floor, showed that the NMD crew and the site radiation protection personnel functioned well. The inspectors noted one minor problem when the spacer of a new fuel bundle was

bent when the bundle was placed in the fuel inspection stand. The inspector noted that no damage to any fuel pins occurred. PECO critiqued the event and shipped the bundle back to the manufacturer for repair.

3.4 (Closed) Unresolved Item 94-27-02; Verification of Single Cell Battery Charger Safety-Related Interface Protection

PECO satisfactorily addressed a concern raised by the inspector in December 1994, regarding separation criteria between a safety-related station battery and a non-safety-related single cell battery charger. PECO used a single cell battery charger, pre-approved by site-engineering, to boost the charge on a single cell, but the terminal cable fuse protection could not readily be verified as an acceptable safety-related ("Q") fuse.

PECO replaced the original fuses in the charger with "Q" fuses, tested the replaced fuses along with newly purchased "Q" fuses from the storeroom at the Valley Forge Laboratories, and concluded that the original fuses would have performed the "Q" function. These results were documented in a non-conformance report. As a corrective action to prevent recurrence, PECO placed labels on single cell chargers stating that "Q" fuses were required. As a further action, PECO placed tamper proof seals on the cover of the fuse access door on the charger as confirmation that the proper fuses were installed.

The inspector reviewed the result of the lab tests and observed the placards placed on the battery chargers. Based on the results of this review, the inspector was satisfied and considered this item closed.

3.5 (Closed) Unresolved Item 95-04-03; Standby Liquid Control System Testing

PECO satisfactorily addressed several procedural weaknesses for the standby liquid control (SBLC) system in-service testing (IST) quarterly ST that were identified by the inspector in February 1995. The weaknesses included: a questionable methodology for verifying SBLC pump flowrate, the use of incorrectly calibrated vibration monitoring equipment, and inconsistencies between the ST procedure and ASME (American Society of Mechanical Engineers) Code, Section XI requirements. The inspector reviewed PECO's response and PEP evaluations and found PECO's actions to be acceptable.

PECO performed PEP evaluations to address the use of incorrectly calibrated vibration monitoring equipment and the inconsistencies between the ST procedure and ASME Code requirements. They determined that several root causes contributed to the vibration probe issue, and initiated several corrective actions, including: improving the system to properly identify and verify test equipment; enhance training in the improved system; and updating and simplifying the vibration equipment calibration requirements. Regarding the ST and ASME code inconsistencies, PECO transitioned the pump IST program to be consistent with ASME Operations and Maintenance Standard, Part-6 (OM-6). This standard was acceptable and modified the previous ASME Section XI requirements and PECO has since revised the ST procedure to be consistent with OM-6 which provides additional clarification regarding testing methodology.

The inspector was satisfied with PECO's response to this issue. All required action items were promptly completed. Based on this review, the inspector concluded that this item is closed.

4.0 ENGINEERING AND TECHNICAL SUPPORT ACTIVITIES (92903, 37551)

The inspectors routinely monitor and assess licensee support staff activities. During this inspection period, the inspectors focused on the activities discussed below.

4.1 Loss of Power to the Technical Support Center due to a Lightning Strike

On July 11, PECO made a one-hour non-emergency event report to the NRC regarding a loss of electrical power to the Technical Support Center (TSC) during the restoration from a lightning strike to an off-site power line. Although the TSC was deenergized for approximately four hours, PECO determined that the power could have been restored promptly in an actual event and subsequently retracted the event report. The inspectors interviewed personnel involved with the issue and concluded that PECO had adequate basis for retracting the event report.

The TSC restoration was delayed because the appropriate procedures had not been updated and two Unit 1 load center electrical breakers had not been fully restored during the release of a blocking clearance following the removal of the Unit 1 EDG. PECO identified several corrective actions to address these weaknesses including: possible revision of the Clearance and Tagging Manual, discussing the event with the project managers, and revision of the required procedures. The inspector determined that PECO's actions were appropriate and had no further questions.

4.2 Independent Safety Engineering Group Findings

The Independent Safety Engineering Group (ISEG) demonstrated an excellent questioning attitude and healthy skepticism during this inspection period by identifying two potentially significant issues. These issues involved a minor unmonitored release of radioactive condensate to the discharge canal and the reliability of an EDG ventilation supply fan.

An ISEG engineer noted that a condensate drain from a mobile air conditioning system in the Unit 3 turbine building had been directed into a drain funnel labeled as an unmonitored release point to the river. The ISEG engineer probed the Chemistry department to determine if the condensate from the air conditioner had been sampled and learned that it had not been sampled. Chemistry personnel subsequently sampled the condensate drain and detected a small amount of radioactive iodine. PECO rerouted the condensate drain to the liquid radwaste system for processing and initiated a PEP investigation. The inspectors reviewed PECO's sample results and determined, based on the small volume of condensate, that the release was not environmentally significant.

In the EDG structure, an ISEG engineer identified that the ventilation supply fan, which is designed to automatically start upon an EDG start, was rotating slowly in the reverse direction. The engineer questioned the ability of the

fan to start during an emergency condition due to the increased starting current that would result from the reverse rotation of the fan. As a result, a troubleshooting and minor maintenance test (TMT) was performed which demonstrated that the fan could start from this condition without tripping the magnetic contacts. The inspectors concluded that ISEG had demonstrated a proper questioning attitude for the above issues, and also that PECO initiated appropriate interim corrective actions.

4.3 (Closed) Unresolved Item 94-08-03; High Pressure Coolant Injection Digital Controller Electromagnetic Interference Evaluation

The HPCI digital upgrade safety evaluation (Mod P00239 50.59 Review, February 7, 1994, page 10) stated that the output current converters were qualified for safety-related use. The service environmental factors such as temperature and seismic were evaluated, but not the electromagnetic interference (EMI) susceptibility. The licensee searched the Nuclear Plant Reliability Data System (NPRDS) data base which indicated no control or failures attributable to EMI. The licensee also evaluated the EMI susceptibility of the current converter by analysis on Action Request No. A0862074 and concluded that the susceptibility was minimal. The inspector reviewed the licensee's analysis and agreed it was acceptable. This item is closed.

4.4 (Closed) Unresolved Item 94-13-03; Diesel Cooling System Valve Testing

This item was open to allow inspector review of PECO's actions to correct a deficiency in the IST of the EDG cooling water supply air-operated valves. Initially, the inspector identified that these valves were being stroke time tested, but not being verified to open to their required throttled position. PECO made appropriate changes to surveillance testing procedures for these emergency service water (ESW) system valves to ensure that their throttled position necessary for adequate cooling is documented and verified during IST. Based on this the inspector closed this item.

4.5 (Closed) Non-Cited Violation 94-27-03; Steam/Water Discharge to Reactor Building During Reactor Water Cleanup System Testing - Unit 2

The inspector reviewed and found that PECO took acceptable corrective actions in response to an event discussed in NRC Inspection Report 94-27 involving an accidental steam/water release into the Unit 2 reactor building. The inspector noted that PECO responded well to this event, but was concerned about the adequacy of the procedural controls over the positioning of the valves through which the release occurred. PECO performed a thorough investigation of this event and developed a number of corrective actions including: a modification system walkdown and test procedure revision to ensure that all valves were included on future tests, and site training with appropriate personnel to emphasize maintaining the proper focus when conducting modification reviews. The inspector had no further questions and closed NCV 94-27-03.

4.6 (Closed) Violation 95-01-01; Inadequate Control of Temporary Shielding Above Hydraulic Control Units -- Units 2 and 3

In NRC Inspection Report 95-01 the inspectors identified that PECO installed temporary lead shielding above the Unit 2 and 3 hydraulic control units (HCUs) without performing a written safety evaluation. The inspector found PECO's follow-up corrective actions acceptable to prevent recurrence. The actions included: revising the applicable engineering and health physics procedures to improve the control of shielding and a review to ensure that the remaining plant shielding installations were properly analyzed. The inspector closed this item.

5.0 PLANT SUPPORT (71750, 92904)

5.1 Radiological Controls

The inspectors examined work in progress in both units to verify proper implementation of health physics (HP) procedures and controls. The inspectors monitored the ALARA (As Low As Reasonably Achievable) program implementation, dosimetry and badging, protective clothing use, radiation surveys, radiation protection instrument use, handling of potentially contaminated equipment and materials, and compliance with RWP requirements. The inspectors observed that personnel working in the radiologically controlled areas met applicable requirements and were frisking in accordance with HP procedures. During routine tours of the units, the inspectors verified that a sampling of high radiation area doors were locked, as required. All activities monitored by the inspectors were found to be acceptable.

5.2 Physical Security

The inspectors monitored security activities for compliance with the accepted Security Plan and associated implementing procedures. The inspectors observed security staffing, operation of the Central and Secondary Access Systems, and licensee checks of vehicles, detection and assessment aids, and vital area access to verify proper control. On each shift, the inspectors observed protected area access control and badging procedures. In addition, the inspectors routinely inspected protected and vital area barriers, compensatory measures, and escort procedures. The inspectors found PECO's activities to be acceptable.

5.3 Emergency Preparedness Annual Exercise: (Closed) Inspector Followup Item 94-20-01; Operations Support Center Repair Team Deployment

The inspectors observed the 1995 Annual Emergency Exercise and concluded that PECO responded excellently to the simulated plant challenges. The drill exercised the major portions of the emergency plan and emergency response procedures and involved only a partial participation by the Commonwealth of Pennsylvania and the State of Maryland. The inspectors observed good command and control, task prioritization, and communications in the Emergency Operations Facility (EOF), Technical Support Center (TSC), the Operational Support Center (OSC), and the control room simulator. The inspectors attended the post-exercise critique and determined that PECO appropriately identified

strengths and weaknesses.

Observation of activities in the EOF, showed that PECO conducted activities very well. Communications between Emergency Response Manager (ERM) in the EOF and the Emergency Director in the TSC allowed quick and efficient discussion of needed emergency action. The staffing of the EOF was conducted well and initial plant status briefings conducted quickly to ensure that all individual had a good initial understanding of the plant conditions. The ERM conducted very good subsequent briefings of the EOF staff and state representatives, at appropriate times. Plant data display systems were quickly established and provided very useful information to the EOF staff.

During the 1994 annual emergency exercise, an area for potential improvement (IFI 94-20-01) was identified regarding the deployment of emergency repair teams from the OSC. The inspector had noted that the damage repair teams received separate task and HP briefings which tended to delay their timely deployment into the field. Additionally, the inspector noted that the some of the repair tasks were not performed simultaneously increasing the time required to effect a repair.

During this exercise, the inspector observed activities in the OSC including: the OSC team leader's activities and several repair team briefings, and accompanied several repair teams into the plant to observe their actions. The inspector noted the task and HP briefings were combined and were clear and thorough. Additionally, the inspector noted repair team performance in the field was good. Tasks were performed in a timely and appropriate sequence. Based on these findings, the inspector was satisfied that PECO had adequately addressed the issue. This item is closed (Closed - IFI 94-20-01).

6.0 MANAGEMENT MEETINGS (71707)

The resident inspectors provided a verbal summary of preliminary findings to the station management at the conclusion of the inspection. During the inspection, the inspectors verbally notified PECO management concerning preliminary findings. The inspectors did not provide any written inspection material to the licensee during the inspection. The licensee did not express any disagreement with the inspection findings. This report does not contain proprietary information.

ATTACHMENT

PART 21 REVIEW ITEMS

<u>Date</u>	<u>Part 21 No.</u>	<u>Title/Resolution</u>
2/15/95	95-03	Barton Model 288A/289A DPS Contact Chatter - PECO's review of the Barton Instruments identified two switches used in passive applications which have no active safety function. PECO concluded the potential defect had no impact on plant safe operation.
2/20/95	95-02	Coltec Lube Oil Pump Flexible Drive Bracket - PECO has inspected two of the four diesel engines during their annual outages and has found no adverse wear or component deterioration. The remaining two diesel engines will be inspected during their annual outage.
7/18/95	95-01	Limitorque Clutch Tripper Jamming in SMB-00 Housing - PECO determined that this Part 21 is applicable at PBAPS. Presently, post-maintenance testing practices electrically stroke all valves as per the maintenance procedure. PECO, however, has identified and is addressing the development of a method to ensure valves are stroked after troubleshooting activities that operate motor-operated valves in manual.
11/10/94	94-093	Rosemount Overpressure Effect Test Procedure changes for Differential Transmitters - PECO determined that no transmitters have been shipped to PBAPS after issuance of the test procedure change. No further review of this Part 21 is required at this time.
11/8/94	94-092	Amerace E7000 Relay Timer - PECO determined that the E7000 relays used at PBAPS are not used where the load at 125vdc exceeds 0.5A and thus is not a concern.
7/29/93	93-059	ITT Corporation Barton Model 580 Instruments Potential Defect - PECO addressed non-conformance issues in a non-conformance report and replaced the affected components during an recent outage window.
5/28/93	93-054	Limitorque Starting Torque at Elevated Temperatures - PECO performed an engineering evaluation of all affected motor operators and found their performance to be acceptable considering the effects of accidental environmental temperatures.
9/9/92	93-012	Impact of Loss of 125vdc Power Source Failure - PECO's evaluation determined that adequate core coverage could be maintained in the event of a loss of a division of 125vdc power with a design based accident.