



PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION

R. D. 1, Box 208

Delta, Pennsylvania 17314

(717) 456-7014

PEACH BOTTOM—THE POWER OF EXCELLENCE

D. B. Miller, Jr.  
Vice President

June 12, 1991

Docket Nos. 50-277  
50-278

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

SUBJECT: Peach Bottom Atomic Power Station - Units 2 & 3  
Reply to Unresolved Items from Combined Inspection Report  
Nos. 50-277/92-80; 50-278/92-80

In response to your letter dated May 11, 1992, which transmitted the Unresolved Items concerning the referenced Inspection Report, we submit our interim corrective actions taken and future actions to address these areas. The subject Inspection Report concerned the findings of an Integrated Performance Assessment Team Inspection conducted February 24 through March 13, 1992.

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

Sincerely,

- cc: R. A. Burricelli, Public Service Electric & Gas
- T. M. Gerusky, Commonwealth of Pennsylvania
- J. J. Lyash, USNPC Senior Resident Inspector
- T. T. Martin, Administrator, Region I, USNRC
- H. C. Schwenm, Atlantic Electric
- R. I. McLean, State of Maryland
- C. D. Schaefer, Delmarva Power

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PDR ADOCK 05000277  
G PDR

IEO/  
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bcc: J. W. Austin	A4-4N, Peach Bottom
J. A. Basilio	52A-5, Chesterbrook
G. J. Beck	52A-5, Chesterbrook
J. A. Bernstein	51A-13, Chesterbrook
R. N. Charles	51A-1, Chesterbrook
Commitment Coordinator	52A-5, Chesterbrook
Correspondence Control Program	61B-3, Chesterbrook
J. B. Cotton	53A-1, Chesterbrook
G. V. Cranston	63B-5, Chesterbrook
E. J. Cullen	S23-1, Main Office
A. D. Dycus	A3-1S, Peach Bottom
A. A. Fulvio	A4-4N, Peach Bottom
D. R. Helwig	51A-11, Chesterbrook
C. J. McDermott	S13-1, Main Office
D. B. Miller, Jr.	SMO-1, Peach Bottom
PB Nuclear Records	A4-2S, Peach Bottom
K. P. Powers	A4-1S, Peach Bottom
J. M. Pratt	B-2-S, Peach Bottom
J. T. Robb	51A-13, Chesterbrook
D. M. Smith	52C-7, Chesterbrook

Restatement of Unresolved Item 92-80-01, "Assessment of Inoperable Control Room Instrumentation"

The Team identified three instances in which the effect of inoperable control room instrumentation had not been effectively evaluated with respect to emergency operating procedure implementation. The Team expressed concern for the total number of inoperable control room instrumentation, the cumulative effect of the inoperable equipment on operator and plant response to transients, and the effectiveness of operational evaluations for inoperable instrumentation.

Response

At the time of the IPAT inspection, the existing list of control room equipment and instrument deficiencies was reviewed by personnel from the Maintenance/I&C and Operations Sections. Each deficiency was assessed for its individual impact on plant operations including transients and emergencies. As a result of these individual assessments, several deficient instruments were identified as having impact on the ability to use emergency operating procedures. The identified deficiencies were assigned higher priority for repair, and in one case, a reading training package and an operator aid were prepared to brief operators about a potentially difficult procedural condition. In addition to the individual deficiency assessments, the net impact of all known deficiencies was evaluated. Although operators were challenged more than desired, operations management was satisfied that the conditions did not degrade the ability to safely operate the plant. The need for improving the assessment and control of control room equipment deficiencies was recognized and stressed to operators. Since the IPAT inspection, an improvement has been observed in the ability of operations personnel to assess the impact of control room equipment deficiencies. This improvement has been exhibited by Shift Management identifying several new deficiencies as having potential impact on emergency and transient procedures. After the possible impacts were identified, the deficiencies were evaluated for compensatory action and assigned higher priority for repair than the normal non-LCO priority. In order to preserve and further enhance the assessment capabilities, formalized guidance is being developed for use by Shift Management each time a deficiency is identified. This guidance will define the scope of review beyond LCO and power generation requirements and will present compensatory action options. Operator training will be used to introduce and emphasize the new guidance. This enhancement will be completed by September, 1992.

Another program improvement being developed is a more effective method of marking the control room controls and indications that have deficiencies. It is expected that improvements will provide the operator with a quick and consistent presentation of pertinent information about deficiencies, and therefore the improvements will enhance his coping ability.

Restatement of Unresolved Item 92-80-02, "Immediate Interim Corrective Actions to Self-Assessment Weaknesses"

The recent station-wide self-assessment identified many opportunities for improved performance. The majority of areas are such that extended improvement programs are appropriate. However, the Team concluded several self-assessment weakness observations may require more immediate corrective measures to reduce the potential for future safety problems. Specifically, the Team observed weaknesses in the administrative controls for maintenance troubleshooting development and work package quality. However, the licensee should assess all self-assessment observations for applicability.

Response

A re-evaluation of the most recent NRC Systematic Assessment of Licensee Performance (SALP), the 1992 site wide self-assessment, the NRC IPAT findings, and the 1992 INPO evaluation preliminary findings was conducted to determine if more immediate correction actions need to be taken on identified issues. A review of these inspections and self-assessment determined that twenty-eight items could potentially warrant more immediate corrective action. This information was transmitted to the responsible groups for resolution. The twenty-eight items which have been re-evaluated for interim corrective action applicability fell primarily into the areas of resource management, adherence to established programs or programmatic controls and human performance. These items were assessed against current performance to determine if any performance or safety problems or regulatory issues exist. Performance and event history were evaluated to identify any recurring problems. The effectiveness of corrective actions taken was also evaluated to determine what actions need to be taken to continue improving performance. Based on event history and performance trends, interim corrective actions were initiated to ensure continuing improvement. These actions are being tracked at the morning Leadership Meeting.

Two specific self-assessment identified weaknesses that require immediate corrective action were troubleshooting development and work package quality. Concerning troubleshooting development, the administrative procedure was revised to address self-identified troubleshooting weaknesses. Training has been initiated for the revised process. The training will include Maintenance / I&C craftsmen and technicians. Work package quality and consistency have been discussed with planning personnel at all hands meetings. The planning process guidance document has been completely re-written and will be placed in effect shortly after required reviews and training is completed. As PIMS continues to be implemented, the ready availability of accurate planning data and information should improve. The effectiveness of troubleshooting and work package quality corrective actions will continue to be monitored through self-assessment.



Restatement of Unresolved Item 92-80-03, "Assessment of Operational Impact of Installed Instrumentation found to be out of Calibration"

The Team noted that the licensee lacked procedures to ensure that permanently installed instrumentation found to be out of calibration is properly assessed for effect on related system operability.

Response

A program to perform Out-Of-Tolerance (OOT) evaluations for installed plant instruments used to determine Tech Spec operability is being developed.

System Managers have been requested to evaluate their system to determine which instruments are used to determine Tech Spec operability. A database is being compiled which will include the instrument, the test used for determining Tech Spec operability, the Surveillance or PM in which it is calibrated, and the calibration frequency.

The database will be used by I&C to identify to the System Manager those instruments found Out-Of-Tolerance during instrument calibrations. Evaluation will be done by the System Manager. System Managers will evaluate the OOT condition and determine the effect it had on the system, determine the compensatory actions required and provide recommendations to Shift Management regarding operability.

The program will be procedurally controlled to establish the actions required upon discovery of an OOT condition of installed plant instrumentation used to determine Tech Spec operability. The program will become effective on July 1, 1992. At that time the data base will be complete and affected personnel will be trained. The program and its effectiveness will be evaluated in December 1993.

Restatement of Unresolved Item 92-80-04, "Adequacy of Modification, Temporary Plant Alteration, and Temporary Procedure Change Document Controls"

The Team noted isolated instances in which procedures and drawings affected by plant modifications had not been properly revised. The Team observed several instances in which controlled drawings affected by TPAs were not properly annotated. Additionally, the Team observed apparent discrepancy with controlled drawing classification such that improper usage may occur.

Response

The review of Modification 5258 resulted in two isolated discrepancies where the Alarm Response Cards (ARCs) had not been updated to reflect the correct type of instrumentation installed and operator training documents had not been revised to indicate the correct tank volumes associated with the setpoint data revised by the modification. The ARCs were updated as part of the mod process to indicate the new tank level, but the change from level switch (LS) to level indicating switch (LIS) was inadvertently missed during the review process. Attention to detail is an area being addressed by site management. Concerning operator training documents, the Mod Training letter that identified the change in tank level was not distributed to the Training Department. This oversight was corrected September 4, 1990, when Administrative Procedure A-14, "Plant Modifications" was revised to include the Superintendent of Training on the Mod Training letter distribution list. Administrative Guideline (AG)-91, "Plant Modifications" approved May 6, 1992, contains the Modification Training Bulletin (Exhibit 6) with the Superintendent of Training on distribution.

A reportability evaluation/event investigation was initiated to investigate the problem of TPA affected drawings not being properly annotated. An audit of all open TPA packages and TPA affected drawings in the control room and at satellite drawing locations was conducted to confirm the list of drawings that needed to be annotated. Additionally, the following corrective actions have been completed:

Administrative Guideline (AG)-17, "Implementation of TPAs" was revised to provide clear direction to include the sheet number of each drawing affected by each specific TPA on the TPA control form. Each identified sheet affected by the TPA is now stamped by the Document Control Group (DCG).

Two 100% audits were performed in the control room and at satellite locations which contained drawings affected by TPAs to ensure that all drawings were annotated correctly.

The database used by DCG to track TPAs and drawings that require annotation has been computerized. The DCG now tags drawings affected by TPAs in their site master file.

The Operations Support Group checks the TPA packages monthly against the DCG database of annotated drawings to ensure accuracy. Any discrepancies are noted and resolved by DCG.

A monthly audit of all drawings affected by TPAs is performed by the DCG in the Control Room and the Station Library to ensure appropriate drawings are annotated. If any discrepancies are identified a 100% audit of all satellite locations is performed.

The scope of drawings identified in AG-77, which require annotation if affected by a TPA, was reviewed by Nuclear Engineering and plant technical staff with regard to drawing classification. This review determined that the scope of drawings that are annotated for TPAs is appropriate.

Temporary changes (TCs) to procedures are captured by the Procedure Issue Counter (PIC) with a complete set also maintained in the Station Library. Designated TCs are captured in the Control Room. Post-use TC review and approval and any required procedure revision are tracked on a database by the Procedure Control Group (PCG). All subsequent users of a procedure with TCs, with a duration other than "one time use", will obtain the procedure with any existing TCs from the PIC.

A listing of all open TCs is issued by PCG so that actions required such as review of TCs within 14 days and revision of procedures required within 60 days is provided.