Docket Nos. 50-352 50-353

Mr. Graham M. Leitch Vice President Limerick Generating Station Philadelphia Electric Company P. O. Box 2300 Pottstown, PA 19464-0920

Dear Mr. Leitch:

SUBJECT: INSPECTION NOS. 50-352/92-11; 50-353/92-11

This refers to your letter of July 2, 1992, in response to our letter dated May 21, 1992.

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

Your cooperation with us is appreciated.

Sincerely,

Original Signed By:

Jeffrey J. Lyash, Acting Chief Reactor Projects Section Division of Reactor Projects

Enclosure: Licensee letter

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cc w/encl:

- D. M. Smith, Senior Vice President Nuclear
- R. Charles, Chairman, Nuclear Review Board
- G. J. Beck, Manager Licensing Section
- G. J. Madsen, Regulatory Engineer Limerick Generating Station

Secretary, Nuclear Committee of the Board

Public Document Room (PDR)

Local Public Document Room (LPDR)

Nuclear Safety Information Center (NSIC)

NRC Resident Inspector

Commonwealth of Pennsylvania

bcc w/encl:

Region I Docket Room

E. Wenzinger, DRP

- J. Lyash, DRP
- B. Norris, DRP
- J. Schoppy, DRP

T. Kenny, SRI-Limerick

RI:DRP

E Wenzinger

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PHILADELPHIA ELECTRIC COMPANY LIMERICK GENERATING STATION P O BOX A SANATOGA, PENNSYLVANIA 19464 (215) 327-1200, EXT. 3000 GRAHAM M. LEITCH July 2, 1992 LIMERICK SENERATING STAVION Docket No. 50-352 License No. NPF-39 U.S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, DC 20555 Limerick Generating Station, Unit 1 SUBJECT: Reply to a Notice of Violation NRC Combined Inspection Report Nos. 50-352/92-11 and 50-353/92-11 Attached is Philadelphia Electric Company's reply to a Notice of Violation for Limerick Generating Station (LGS) Unit 1, which was contained in the NRC Combined Inspection Report Nos. 50-352/92-11 and 5G-353/92-11, dated May 21, 1992. The Notice of Violation identifies the failure to follow an approved maintenance procedure during restoration of the Reactor Water Cleanup valve (44-1029) to its "as found" position following containment leak testing. The attachment to this letter provides a restatement of the violation identified followed by our response. Additionally, you requested that we describe actions planned or taken to address the apparent recurring problems in this area. These actions are also described in the attachment to this letter. If you have any questions or require additional information, please contact us. Very truly yours, LAHophine for GML Graham M. Leitch DCS: cah Attachment T. T. Martin, Administrator, Region I, USNRC T. J. Kenny, USNRC Senior Resident Inspector, LGS 9207090011

bcc: D. M. Smith = 52C-7
D. R. Helwig = 63C-1
J. W. Durham = \$26-1
J. Doering, Jr. - ADM5-1
J. P. O'Rouke - SMB1-1
R. W. Boyce - ADM5-1
G. J. Madsen - SSB3-4
J. B. Cotton - 53A-1
J. J. McElwain - SSR4-3
G. J. Beck, Jr., - 52A-5
R. N. Charles - \$3A-1
E. W. Callan - SMB3-2
Secretary, NCB - 51A-13
Correspondence Release Point - SMB1-2
DAC
PA DER BRP Inspector - SMB2-2
Commitment Coordinator 52A-5

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Reply to a Notice of Violation

Restatement of the Violation

During an NRC inspection conducted on March 15, through April 25, 1992, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedures for NRC Enforcement Actions," 10 CFR Part 2, Appendix C (1992), the violation is listed below:

Limerick Technical Specification 6.8.1.d. requires that written procedures be established implemented and maintained to cover surveillance and test activities of safety-related equipment. Step 7.1.b. of local leak rate test ST-4-LLR-092-1, Revision 0, "Feedwater," directs the test personnel to return the valves listed in the Tag Accountability Log to their as-found position, unless otherwise directed by shift supervision. The as-found positions are established and recorded in step 6.3.1.a. of the test.

Contrary to the above, on March 26, 1992, during the performance of step 7.1.b of procedure ST-4-LLR-092-1, reactor water cleanup valve 44-1029 was improperly positioned to the locked open position instead of to the required as-found position of closed. This occurred when the test personnel operated the valve without ascertaining what the as-found position was, as required by the test procedure. The misposition resulted in draining about 13,000 gallons of water from the reactor cavity.

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

RESPONSE

Admission of Violation

Philadelphia Electric Company (PECo) acknowledges the violation.

Reason for the Violation

The cause of the violation is procedural non-compliance due to lack of attention to detail on the part of the individual performing Local Leak Rate Test (LLRT) procedure ST-4-LLR-092-1, "Feedwater." Contributing to the event was a procedural abiguity and less than adequate pre-job planning and communications.

Prior to performance of procedure ST-4-LLR-092-1, Planning and Maintenance technical staff had provided Operations personnel with a list of procedures that contained valves which required blocking clearance to support test performance. Valve 44-1029 was not identified on the list as requiring blocking to support performance of procedure ST-4-LLR-092-1. Subsequent verbal communications between Maintenance technical staff and Operations personnel identified the need to block valve 44-1029 closed, however, these communications were not documented in pre-job planning and the block was not applied.

On March 23, 1992, permission was granted to commence performance of procedure ST-4-LLR-092-1. This procedure consists of five laak rate tests in one ST procedure. The five tests were completed at approximately 0300 hours on March 26, 1992. At 0700 hours, the restoration portion of the procedure began. A pre-job briefing was conducted prior to restoration and the precaution against opening valve 44-1029 was communicated with the work team. Normal practice for the restoration of systems following performance of ST procedures consists of using the working copy of the tag accountability log containing the "as found" signoffs. Contrary to this practice, the technicians were using a copy of the log that did not contain the "as found" position of valve 44-1029 (unlocked and closed). The "normal operating position" of valve 44-1029 as listed in the ST procedure tag accountability log is locked open. Using the blank copy of the tag accountability log, the technician incorrectly returned valve 44-1029 to its normal operating position (locked open).

Corrective Action and Results Achieved

Upon opening valve 44-1029 at approximately 1004 hours, the technician heard flow through the valve. Recognizing this as an unexpected condition, the technician notified the job leader and retrieved the original test which was at the job location. He then identified the "as found" position to be unlocked and closed, and reclosed the valve.

At approximately 1010 hours, the Operations Shift Supervisor notified the Maintenance Foreman responsible for the testing that the Unit 1 Reactor Cavity was losing level. The Maintenance foreman contacted the job leader and communicated this concern. The simultaneous activities of the technician correcting the valve position and the communications between the Shift Supervisor, the Maintenance Foreman and the job leader, mitigated the event at 1012 hours.

The Maintenance Foreman requested the Operations Shift Supervisor to apply a blocking tag to 44-1029 and block the valve closed. This action was completed on March 26, 1992.

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Corrective Actions Taken or Planned to Avoid Future Non-Compliance

The following immediate actions were taken to avoid future non-compliance.

- O Prior to the performance of any further LLRTs, Maintenance Technical Staff reviewed all LLRTs to ensure that any boundary valves which, if mispositioned, had the potential to drain the vessel, were properly identified and clearances applied.
- o The job leader and technician were disciplined and counseled on procedural compliance and attention to detail.
- o Team meetings were held to reaffirm and define the use of working copies of procedures and Administrative Guide AG-79, "Procedure Compliance."

The following actions are planned to avoid future non-compliance.

- o By August 15, 1992, prior to the next refueling outage, human factoring enhancements will be performed on the LLRT procedures in the areas of valve number/valve description to eliminate all normal valve operating position: from the procedures, and insert a list of locked valves in the Precautions and Limitations section of LLRT procedures. Steps will be taken to ensure that all LLRTs with the potential to drain the reactor will have a clearance associated with the test. This clearance will block closed all of the valves with such potential.
- An enhanced training program for the performance of LLRTs will be implemented prior to the upcoming Unit 2 Refueling Outage. This training will provide further understanding of the system impact and potential operations impact from performance of LLRTs. All maintenance personnel performing LLRTs will be required to be retrained prior to performing any future LLRTS.

In ords to address apparent recurring problems in the area of procedure compliance during maintenance activities, Maintenance Supervision has reviewed the Maintenance Guideline, "Conduct of Maintenance. Enhancements including creation of the Maintenance/Instrumentation and Controls Training Bulletin (MTB) and clear expectations of a "working copy," based on successful guidance given to Operations personnel in the Operations Manual and in Administrative (A) procedure A-7, "Shift Operations," will be incorporated. These enhancements will improve Maintenance personnel's understanding of procedural compliance and will improve communication methods of procedural compliance issues

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through the use of an MTB to be issued as events of interest occur at Limerick or elsewhere in the Industry. These enhancements are expected to be completed by August 1, 1992.

Additionally, continuing training will be conducted prior to every future refueling outage to identify issues regarding procedural compliance and attention to detail including appropriate MTBs.

Date When Full Compliance was Achieved

. . .

Full compliance was achieved on March 26, 1992 upon proper completion of the procedure. Necessary immediate corrective actions to assure procedure compliance were completed on April 23, 1992.