U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Report No. 50-278/85-22

Docket No. 50-278

License No. DPR-56

Licensee: Philadelphia Electric Company
2301 Market Street
Philadelphia, Pennsylvania 19101

Facility Name: Peach Bottom Atomic Power Station Unit 3

Inspection at: Delta, Pennsylvania

Inspection conducted: June 10 - 13, 1985

Inspectors: T. P. Johnson, Sr. Resident Inspector
D. J. Florek, Lead Reactor Engineer

Reviewed by: Robert M. Gallo FOR
J. E. Beall, Project Engineer

6/18/85
date

Approved by: Robert M. Gallo
Robert M. Gallo, Chief
DRP, Section 2A

6/18/85
date

Inspection Summary: June 13, 1985 (Inspection Report 278/85-22) special inspection regarding routine safety and followup of events surrounding an NRC regional inspector's observance of an apparent inattentive Unit 3 on-shift licensed reactor operator. This inspection involved 10 hours by one resident inspector and one regional inspector.

Results: Concerns were identified regarding: (1) the apparent inattentiveness to licensed duties by the on-shift Unit 3 licensed reactor operator, and (2) the operator's apparent enticement of an NRC regional inspector as concluded by the licensee's investigation.

DETAILS

1. Persons Contacted

1.1 Licensee Personnel

*R. S. Fleischmann, Manager, Peach Bottom Atomic Power Station
*D. C. Smith, Superintendent Operations

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

1.2 NRC Inspection Participants

T. P. Johnson, Senior Resident Inspector
D. J. Florek, Lead Reactor Engineer

2. Purpose, Background and Sequence of Events

2.1 Purpose

In order to support inspection of the Peach Bottom Unit 2 outage recovery activities the regional inspector had been on-site since June 9, 1985, observing the Unit 2 containment integrated leak rate test (ILRT).

On June 10, 1985, at approximately 6:15 a.m. an NRC regional inspector was present in the control room, while inspecting the Unit 2 containment ILRT. At that time, the inspector observed the Unit 3 on-shift licensed reactor operator with his eyes closed and head tilted back while sitting in a chair adjacent to the reactor control panel.

The purpose of this special inspection is to review the events surrounding an NRC regional inspector's observance of apparent inattentiveness to licensed duties by the Unit 3 on-shift licensed reactor operator.

2.2 Background

Peach Bottom Units 2 and 3 share a common control room (see Attachment 1). The following licensed personnel are normally assigned on-shift duties in the control room: Unit 2 reactor operator, Unit 3 reactor operator, control operator and shift supervisor. The Unit 2 reactor operator has responsibilities for the south end of the control room (Unit 2 control boards), the Unit 3 reactor operator has responsibilities for the north end of the control room (Unit 3 control boards) and the control operator has responsibilities for the central (common) control boards. The shift supervisor has a desk in the control room on the north (Unit 3) side. In addition, each shift has a senior licensed shift superintendent who has an office in the control room; however, this office is outside the area of the control room panels.

At the time of the occurrence, Unit 3 was operating at 78% power in extended core flow at the end of cycle six. Unit 2 was in cold shutdown with the containment ILRT in progress. No testing nor abnormal plant operations were in progress at Unit 3.

2.3 Sequence of Events

Date	Time	Event
6/9/85	5:00 a.m.	NRC regional inspector on-site to observe Unit 2 containment ILRT (Sunday).
6/10/85	5:00 a.m.	NRC regional inspector again on-site to observe Unit 2 containment ILRT (Monday).
6/10/85	5:06 a.m.	NRC regional inspector enters control room and exits one minute later.
6/10/85	6:05 a.m.	NRC regional inspector re-enters control room to discuss ILRT with test director.
6/10/85	Approx. 6:15 a.m.	NRC regional inspector observes on-shift Unit 3 licensed reactor operator with eyes closed, and head tilted back on his chair. Inspector informed Shift Supervisor, who talks to operator. Inspector exits control room.
6/10/85	6:26 a.m.	NRC regional inspector again re-enters control room and observes that Unit 3 reactor operator is attentive to duties. Inspector exits control room a few minutes later.
6/10/85	7:00 a.m.	Unit 3 reactor operator relieved due to shift change. NRC regional inspector informs NRC resident inspectors of observations regarding the Unit 3 reactor operator.
6/10/85	8:00 a.m.	NRC regional inspector informs Superintendent Operations of situation.

6/10/85	8:15 a.m.	Region I management notified of situation.
6/10/85	Approx. Noon	NRC regional and resident inspectors discuss situation with the Superintendent Operations.
6/10/85-6/11/85	11:00 p.m. - 7:00 a.m.	Licensee conducts interviews with control room participants and performs investigation
6/11/85	8:00 a.m.	NRC regional inspector discusses situation with Manager, PBAPS and Superintendent Operations
6/11/85	Approx. 9:00 a.m.	Licensee takes disciplinary action against Unit 3 licensed reactor operator.
6/11/85	Approx. Noon	NRC resident inspector discusses situation and disciplinary action taken with Manager, PBAPS and Superintendent Operations.
6/12/85	9:00 a.m.	NRC resident inspector reviews written statements from operators involved and written investigation by the licensee. Further discusses event with Manager, PBAPS.
6/12/85	5:00 p.m.	After concluding the PBAPS SALP meeting, NRC RI management are briefed on situation by licensee management.

3. Discussion

(Refer to the enclosed figure, Attachment 1, for control room locations as noted by numbers in parentheses.) At 6:05 a.m. on June 10, 1985, the NRC regional inspector entered the control room (1) from the Unit 2 side vital door. The NRC regional inspector discussed ILRT items with the ILRT test director and was preparing to leave the control room with the test director when the regional inspector observed the on-shift Unit 3 reactor operator sitting in a chair (3) at the Unit 3 reactor control panel in a questionable physical position. The inspector crossed the control room to the Unit 3 side (4) to obtain a better observation of the Unit 3 reactor operator's physical position. The inspector noted that the operator had his eyes closed and his head tilted back on his chair. The inspector then moved to the shift supervisors desk (5) and told him that there appeared

to be a problem with the Unit 3 licensed reactor operator. The shift supervisor walked over to observe the Unit 3 reactor operator (6) and the inspector remained at the shift supervisor's desk (5). The shift supervisor then spoke the operator's name in an apparently normal tone of voice. The regional inspector's initial recollection of the event observed what appeared to be the shift supervisor reaching out to the operator and the inspector assumed physical contact was made. However, in subsequent recollections, the inspector could not be sure that physical contact was in fact made. Following the interaction with the shift supervisor, the operator quickly restored his head to an erect position, with eyes opened and appeared to be aware of his surroundings. The shift supervisor returned to his normal station (5) and informed the inspector he would "keep an eye on the operator". The inspector then left the control room (1) with the ILRT test director.

Approximately 10 minutes later the inspector revisited the control room and no further problems were noted. The inspector discussed the Unit 3 reactor operator's status with the shift supervisor (7) and the shift supervisor indicated that the operator was capable of maintaining his station. The shift supervisor also indicated that he did not believe the operator was "sleeping" at the time.

The regional inspector informed the resident inspectors of the events at about 7:00 a.m. on June 10, 1985, and informed the Superintendent Operations at approximately 8:00 a.m. while in the bridge connecting the administration building to the power block. AT 8:15 a.m. the resident inspector notified Region I management of this situation. The resident inspector and the regional inspector had further discussions with the Superintendent Operations at approximately noon the same day.

On June 11, 1985, at approximately 8:00 a.m. additional discussions were held between the regional inspector and the Manager, PBAPS and Superintendent Operations regarding the assumed physical contact between the shift supervisor and operator. During these discussions, the regional inspector indicated that he could not be sure that physical contact was indeed made when the shift supervisor initially spoke to the operator.

The licensee conducted an investigation of the event on June 10 - 11, 1985, during "Z" shift (11 p.m. to 7 a.m.). The investigation was performed by the Operations Engineer and reviewed by the Manager, PBAPS and Superintendent Operations. Disciplinary action was taken by the Manager, PBAPS regarding the performance of the Unit 3 reactor operator at 9:00 a.m. on June 11, 1985. The resident inspector subsequently reviewed the licensee's investigation findings including the following items:

-- Statement of on-shift Unit 3 licensed reactor operator

-- Statement of the on-shift Shift Supervisor

-- Statement of the on-shift Shift Superintendent

-- Investigation report by the Operations Engineer

In summary, the licensee's investigation concluded the following:

-- The on-shift Unit 3 reactor operator's eyes were closed, however he was not asleep.

-- The NRC regional inspector observed the Unit 3 reactor operator with his eyes closed.

-- The Unit 3 reactor operator was enticing the NRC regional inspector to believe he was asleep.

The resident inspector discussed the results of the licensee's investigation and the disciplinary actions taken regarding the performance of the Unit 3 reactor operator with the Manager, PBAPS at approximately 9:00 a.m. on June 12, 1985.

4. Conclusion

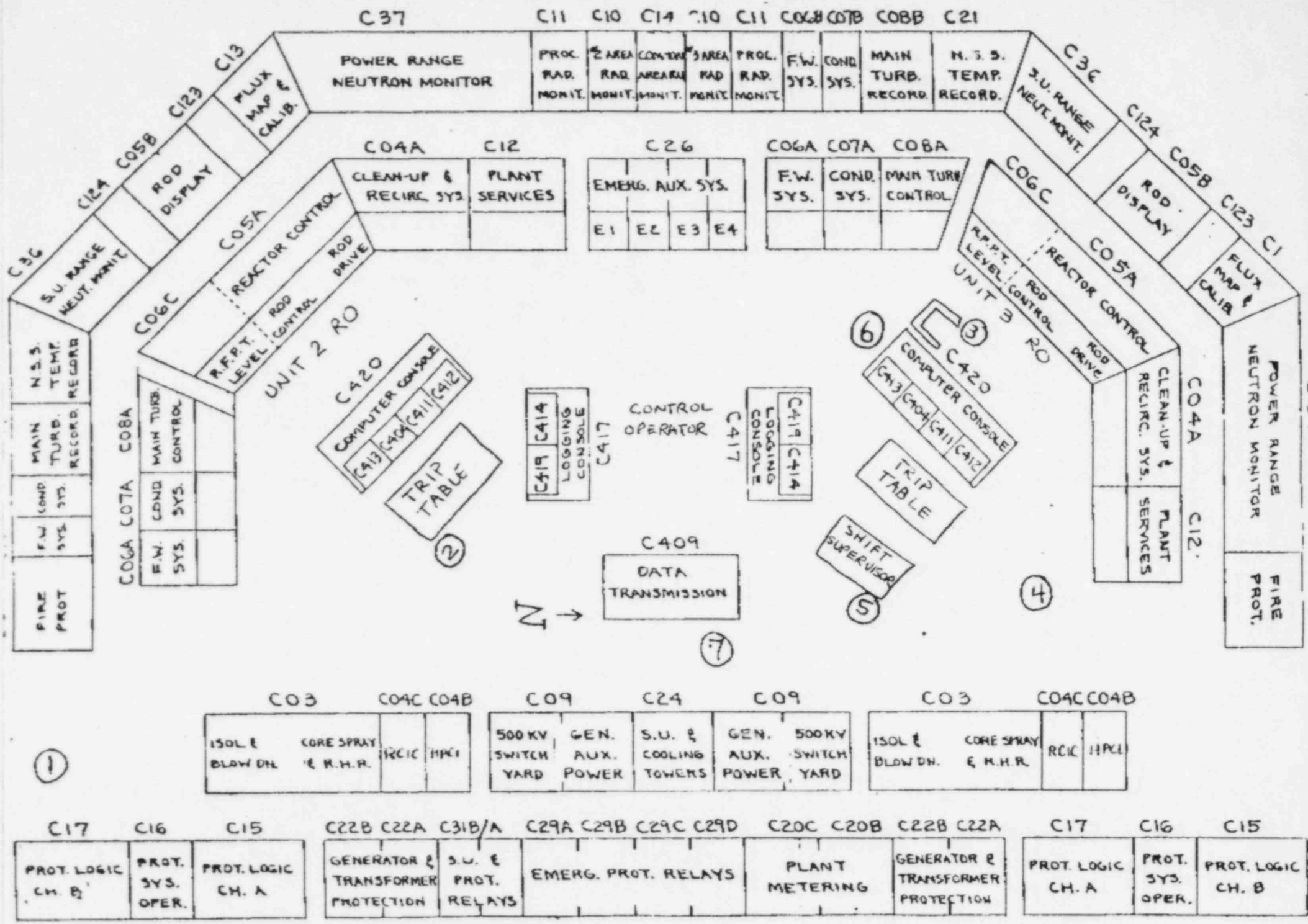
The on-shift Unit 3 licensed reactor operator, the operator "at the controls," was apparently inattentive in that his eyes were closed and his head was tilted back on his chair while at the Unit 3 reactor control panel. In addition, the licensee's evaluation concluded that the reactor operator was apparently enticing the NRC regional inspector to believe that he was asleep. (UNR 278/85-22-01)

5. Management Meetings

5.1 On June 12, 1985, following the previously scheduled Peach Bottom SALP meeting, NRC Region I management were briefed by licensee management regarding this situation. Individuals attending this briefing are included in Attachment 2.

5.2 On June 13, 1985, a verbal summary of preliminary inspection findings was provided to the Manager, PBAPS and to the Superintendent Operations at the conclusion of the special inspection. No draft inspection report material was provided to the liensee during the inspection.

ATTACHMENT 1



PEACH BOTTOM UNITS 2 & 3 CONTROL ROOM

ATTACHMENT 2

NRC:RI and Licensee Management Meeting on June 12, 1985

Name	Title
T. P. Johnson	NRC:RI Senior Resident Inspector
D. J. Florek	NRC:RI Lead Reactor Engineer
R. M. Gallo	NRC:RI Chief, Reactor Projects Section 2A
S. J. Collins	NRC:RI Chief, Reactor Projects Branch 2
T. E. Murley	NRC:RI Regional Administrator
R. W. Starostecki	NRC:RI Director, Division of Reactor Projects
R. S. Fleischmann	PECo Manager, PBAPS
W. T. Ullrich	PECo Superintendent, Nuclear Generation Division
M. J. Cooney	PECo Manager, Nuclear Production
S. L. Daltroff	PECo Vice President, Electrical Production
V. S. Boyer	PECo Senior Vice President, Nuclear Power