December 5, 1997 Mr. D. M. Smith, President PECO Nuclear Nuclear Group Headquarters Correspondence Control Desk P. O. Box 195 Wayne, PA 19087-0195 SUBJECT: INSPF: JION REPORT NOS. 50-352/97-07 AND 50-353/97-07 - REPLY Dear Mr. Smith: This letter refers to your November 26, 1997, correspondence, in response to our October 27, 1997, letter. 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 Clifford J. Anderson, Chief Project Branch No. 4 Division of Reactor Projects Docket Nos. 50-352; 50-353 cc: G. A. Hunger, Jr., Chairman, Nuclear Review Board and Director - Licensing W. MacFarland, Vice President - Limerick Generating Station J. L. Kantner, Manager, Experience Assessment Secretary, Nuclear Committee of the Board R. A. Calvan, Regional Director, FEMA, Region III (EP Exercise/IRs Only) I201 Commonwealth of Pennsylvania 12180049

Mr. D. M. Smith

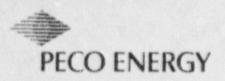
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10 CFR 2.201

November 26, 1997

Docket Nos. 50-352 50-353

License Nos. NPF-39 NPF-85

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

SUBJECT:

Limerick Generating Station, Units 1 and 2

Reply to a Notice of Violation

NRC Integrated Inspection Report Nos. 50-352/97-07 and 50-353/97-07

Attached is PECO Energy Company's reply to a Notice of Violation for Limerick Generating Station (LGS), Units 1 and 2, that was contained in your letter dated October 27, 1997. The Notice identified violations concerning: 1) a number of valves that were inadequate. I locked, and 2) issues associated with the Foreign Material Exclusion (FME) program. The attachment to this letter provides a restatement of each violation followed by our reply.

If you have any questions or require additional information, please contact us.

Very truly yours.

Attachment

H. J. Miller, Administrator, Region I, USNRC

A. L. Burritt, USNRC Senior Resident Inspector, LGS

w/attachment

90,120102000

Attachment Docket Nos. 50-352 and 50-353 November 26, 1997 Page 1 of 4

# Reply To a Notice of Violation

### Violation A

# Restatement of Violation

During an NRC inspection conducted on July 22 through September 15, 1997, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

A. Units 1 and 2 Technical Specification (TS) 6.8.1 requires, in part, that written procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33 recommends Administrative Procedures for Equipment Control (e.g., locking and tagging) as activities that should be covered by written procedures. Administrative procedure A-C-008, Control of Locked Valves and Devices, written to comply with TS 6.8.1, requires in part, that a locking device be applied through the valve handwheel or other operating mechanism to restrict operation of the valve, for valves listed on the Locked Valve List exhibits.

Contrary to the above, between August 18 and 28, 1997, the inspector identified valve locking devices not applied through the valve handwheel or other operating mechanism to restrict operation of valves listed on the locked Valve List exhibits. Additionally, operations personnel identified other similar valves during a subsequent walkdown of accessible locked valves.

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

#### REPLY

#### Admission of the Violation

PECO Energy acknowledges the violation.

# Reasons for the Violation

The cause of the failure to properly apply locking devices were insufficient recurring training for some personnel regarding proper application of locking devices, an infrequently performed task with specific expectations; lack of sufficient inspections and surveillances to verify the condition of locking devices resulting in devices which had deteriorated due to rust; and, a valve design (Thandle) which is difficult to secure using a standard cable and lock.

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### Corrective Actions Taken and Results Achieved

A briefing sheet was issued to all operations and maintenance personnel to reinforce the expectations for restoration of locked devices. In addition, all site personnel were briefed on locked device expectations, including consideration of material condition when locking devices.

All normally accessible locked valves (2080 valves) were inspected to identify and correct deviations from administrative requirements. Thirty-eight (38) valves were found to be improperly locked and nineteen (19) devices were found to have locking devices in a deteriorated condition. All devices were found to be in the correct position. The improperly locked devices were immediately corrected. Corrective maintenance action requests were initiated for locked devices which were in poor physical condition and the devices were entered in the locked valve log as unlocked devices in accordance with procedure.

### Corrective Actions to Avoid Future Noncompliance

Recurring training for appropriate personnel regarding proper locked device manipulation is being developed. The first cycle of recurring training will be completed by April, 1998.

A process will be created to periodically sample a portion of the locked devices and ensure they are properly locked. This process will be in place by the end of December, 1997.

An evaluation is in progress to identify an improved mechanism for securing T-handle valves. This evaluation is expected to be completed by March, 1998.

### Date When Full Compliance was Achieved

The improperly locked valves identified by the inspector were restored to compliance with procedural requirements by August 28, 1997. The inspection of additional locked valves was completed and all deviations from administrative requirements were corrected by September 24, 1997. No devices were found out of position at any time during the initial discovery or follow-up inspections for this issue.

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### Violation B

# Restatement of Violation

During an NRC inspection conducted on July 22 through September 15, 1997, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violation is listed below:

B. Administrative procedure A-C-131, Foreign Material Exclusion, requires in part that FME control recommendations be defined and included in the work package, and that workers shall understand and adhere to Foreign Material Exclusion (FME) requirements.

Contrary to the above, workers failed to adequately understand and adhere to FME requirements and on June 25, 1997, a small piece of cloth was found in the Unit 2 high pressure coolant injection (HPCI) drain line flow orifice, resulting in operators declaring the Unit 2 HPCI system inoperable.

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

#### REPLY

#### Admission of the Violation

PECO Energy acknowledges the violation.

## Reasons for the Violation

The primary cause of this event was personnel error, related to less than adequate implementation of PECO Nuclear's Foreign Material Exclusion (FME) program. The exact origin of this piece of cloth was not determined, however, it was most likely introduced during the System work performed during the 2R04 refueling outage in February 1997. This would have been caused by less than adequate: worker attention to detail and immediate oversight of activities to ensure compliance with appropriate FME practices.

An associated root cause for this event was less than adequate site-wide implementation of the FME program. During and immediately after the 2R04 refueling outage, a number of foreign material intrusion events were identified. Station management concluded that these events resulted from less than adequate site-wide implementation of the FME program, and therefore initiated a broad-based corrective action plan.

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# Corrective Actions Taken and Results Achieved

Corrective maintenance on the HPCI System identified a small piece of cloth (circular, approximately 1" in diameter) in the turbine exhaust drain pot drain line, upstream of the flow orifice. The drain pot drain line was cleaned and reinstalled. The HPCI system was satisfactorily post-maintenance tested.

# Corrective Actions to Avoid Future Noncompliance

The corrective actions to avoid future noncompliances of this nature are related to addressing site-wide implementation of the FME program. These actions were initiated prior to this event, are in progress, and include:

- Incorporation of FME training in all maintenance continuing training sessions.
- Development of a site-wide, multi-organizational task team to identify issues was current FME procedures and practices.
- · Development of a communication plan to enhance FME awareness.
- Clarification and reinforcement of management expectations for performance.
- Evaluate, and revise as necessary, the FME implementing procedures (including consideration of industry best practices).
- Perform a follow-up self-assessment in 1998 of FME program implementation.

The majority of these actions are scheduled to be completed by the end of the first quarter of 1998.

# Date When Full Compliance was Achieved

Full compliance was achieved on June 27, 1997, when corrective maintenance was completed on the HPCI System and the System satisfactorily completed a post-maintenance test.