Enclosure 2

APPENDIX B

NOTICE OF DEVIATION

Public Service Electric and Gas Company
Salem Nuclear Generating Station
Units 1 and 2

Docket Nos: 50-272

License Nos: DPR-70

During an NRC inspection conducted on March 23, 1995 - May 6, 1995, a deviation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the deviation is listed below:

The basis for Salem Unit 1 Technical Specification 3.8.1 states that the surveillance requirements for demonstrating operability of the Emergency Diesel Generators (EDG) are based on the recommendations of Regulatory Guide (RG) 1.9, and RG 1.108. RG 1.108 (Rev. 1, August 1977), a licensee commitment, requires nonconcurrent testing of redundant Emergency Diesel Generators during normal plant operation.

Contrary to the above, at least two EDG output breakers were simultaneously closed from 4:19 a.m. until 5:22 a.m. on May 5, 1995, to support concurrent testing of the 1A and 1C Emergency Diesel Generators.

Please provide to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555, with a copy to the Regional Administrator, Region I, and a copy to the NRC Resident Inspector at Salem Generating Station, in writing within 30 days of the date of this Notice, (1) the reason for the deviation, or if contested, the basis for disputing the deviation, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further deviations, and (4) the date when your corrective action will be completed. Where good cause is shown, consideration will be given to extending the response time.

Dated at King of Prussia, Pennsylvania
this 24 day of May 1995

Enclosure 3

APPARENT VIOLATIONS CONSIDERED FOR ESCALATED ENFORCEMENT

10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," requires, in part, that licensees shall promptly identify and correct conditions adverse to quality, and for significant conditions adverse to quality, the licensee shall also document the condition, notify appropriate levels of management, and ensure action to preclude recurrence of the condition.

Contrary to the above, the Salem engineering staff did not promptly identify, correct, notify appropriate levels of management, or ensure action to preclude recurrence for the following conditions:

(1) An oil sample laboratory report, dated August 4, 1994, recommended resampling and changing the oil on the no. 21 high-head safety injection pump based upon a ten-fold increase in wear particle concentration.

(2) An oil analysis, dated November 28, 1994, identified high wear particle concentration in the no. 22 high-head safety injection pump speed increaser oil.

On March 20, 1995, the responsible system engineer issued Equipment Malfunction Identification System (EMIS) tags on the above components identifying the degraded conditions.

(3) A lab report, dated October 6, 1994, recommended resampling the no. 23 Auxiliary Feed Water (AFW) turbine lube oil due to a trace amount of water found and a marked increase in wear particle concentration.

On March 27, 1995, the system engineer issued an EMIS tag addressing this degraded condition. The inspector noted that the engineer had little or no documentation on the above problems other than the initial lab reports.

(4) In May 1994, a system engineer initiated a work request to inspect the 2A1 28 VDC battery charger ground detection circuit (GDC) wiring. He initiated the request following a system walk-down of the 28 V battery chargers that revealed Unit 1 chargers were configured differently than Unit 2 chargers. However, the work order to conduct the charger internal inspection did not occur until late April 1995.

(5) Licensee Event Report (LER) 95-05 identified seven instances of vendor identified out of tolerance pressurizer code safety valves (PSVs). The report stated that, between May 8, 1990 and January 14, 1995, the vendor identified that the PSVs did not meet the 1% tolerance required by Technical Specification 4.0.5 requirement for Salem Unit 1. The LER further stated that the four instances between November 14, 1994 and January 14, 1995 each identified that two of the installed three PSVs did not meet the Technical Specification (TS) 4.0.5 tolerance requirement. In each case, the vendor notified the appropriate system engineer by telephone, and followed the telephone report with a written report. In all cases, Salem personnel informed by the vendor failed to initiate an Incident Report. As a result, PSE&G did not initiate timely root cause or reportability evaluations.