FEB 26 1993

Docket Nos. 50-352
50-353

Mr. D. M. Smith
Senior Vice President -
Nuclear
Philadelphia Electric Company
Nuclear Group Headquarters
Correspondence Control Desk
P. O. Box 195
Wayne, PA 19087-0195

Dear Mr. Smith:

SUBJECT: NRC Combined Inspection 50-352/93-04; 50-353/93-04

An inspection of the radiological controls program was conducted at the Limerick Nuclear Generating Station by Messrs. R. L. Nimitz and L. L. Eckert of this office during the period January 19-22, 1993, and February 1-3 and 8-12, 1993. The findings of the inspection were discussed with Mr. J. Doering on January 22, and February 3, 8, and 12, 1993.

Areas reviewed during the inspection were important to health and safety and are fully discussed in the enclosed inspection report. The areas reviewed included planning and preparation for the Unit 2 refueling outage in consideration of the identification of failed fuel, organization and staffing, external and internal exposure controls, radioactive material controls, and the ALARA program. Also reviewed were the circumstances, evaluations and corrective actions associated with two events that occurred on May 31, 1992, and January 27, 1993. The events involved workers handling traversing incore probe (TIP) tubing under the Unit 1 and Unit 2 reactor vessels.

Overall, the inspector concluded that generally effective planning and preparation for reactor refueling, in consideration of failed fuel, was performed. The inspector also concluded that timely efforts were taken to update radioactive waste shipping data to reflect the potential for additional radionuclides attributable to the failed fuel. Observations during the outage identified generally good efforts to maintain radiation exposures as low as reasonably achievable (ALARA).

Regarding the two events involving TIP tubing, although the inspector concluded that no significant intake of airborne radioactive material by, or external exposure of, personnel occurred during either the May 31, 1992, or the January 27, 1993, events there was the potential for a significant intake during the January 27, 1993 event. Further, apparent violations of NRC requirements were identified in both events. Regarding the May 31, 1992, event, one apparent violation of the radiation work permit program was identified. The inspector found that workers failed to inform radiological controls personnel of changes in their work location, resulting in workers testing TIP tubing under the reactor vessel without the knowledge of radiological controls personnel.

Regarding the January 27, 1993, TIP tubing event, two apparent violations were identified. The inspector found that adequate radiological surveys were not performed and workers were not provided adequate instructions to minimize their exposure to high levels of radioactive contamination. We are particularly concerned that lessons learned from the May 31, 1992, event were not appropriately incorporated into program controls in that thorough planning had not been performed by radiological controls personnel prior to initiation of the work. In addition, we are concerned that the introduction of high levels of radioactive contamination into the work area, and the lack of effective radiological oversight of the January 27, 1993, TIP work, resulted in the potential for a significant intake of radioactive material by personnel.

In addition to the above apparent violations, two additional violations involving failure to follow station procedures were identified in association with other work activities. Specifically, radiation protection personnel failed to adhere to the radiation work permit (RWP) during fuel inspection activities and to perform required surveys, and failed to provide adequate air sampling during TIP drive work. One non-cited violation involving failure of workers performing fuel pool work to sign-in on the proper RWP was also identified.

Further, in addition to the TIP events discussed above, our review of your performance in the area of radiological controls over the past year has identified that a number of radiological controls problems have occurred which indicate that effective controls over on-going activities, taking into consideration the increase in the radiological source term at the station, may not yet be in place. In light of this and because the January 27, 1993, event had the potential to result in a significant personnel exposure, we are concerned about the effectiveness of your radiological controls program. Accordingly, we have scheduled an enforcement conference with you at the NRC Region I office for 9:00 a.m. on March 16, 1993. This enforcement conference will be open to public observation in accordance with the Commission's trial program as discussed in the enclosed *Federal Register* notice (Enclosure 2). The purposes of this conference are to discuss the apparent violations, their causes and safety significance; to provide you the opportunity to point out any errors in our inspection report; and to provide an opportunity for you to present your proposed corrective actions.

At this conference, you should be prepared to discuss your overall assessment of the performance of the radiological controls program over the past year, as a whole, in light of the above discussed matters, and what actions you have taken to preclude recurrences of similar problems. You should also be prepared to discuss the above identified apparent violations. We are particularly interested in your assessment of the January 27, 1993, event and whether this event could have potentially resulted in an intake of radioactive material in excess of NRC limits. In addition, this is an opportunity for you to provide any information concerning your perspective on 1) the severity of the issue, 2) factors that NRC considers when it determines the amount of a civil penalty that may be assessed in accordance with Section VI.B.2 of the Enforcement Policy, and 3) the possible basis for exercising discretion in accordance with Section VII of the Enforcement Policy.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room. You will be advised by separate correspondence of the results of our deliberations on this matter. No response regarding the apparent violations is required at this time.

Your cooperation with us is appreciated.

Sincerely,

Original Signed By:
Richard W. Cooper

Richard W. Cooper, II, Director
Division of Radiation Safety
and Safeguards

Enclosures:
1. NRC Combined Inspection Report No. 50-352/93-04; 50-353/93-04
2. *Federal Register* Notice

cc w/encls:
R. Charles, Chairman, Nuclear Review Board
D. R. Helwig, Vice President - Limerick Generating Station
G. J. Beck, Manager - Licensing Section
G. Madsen, Regulatory Engineer - Limerick Generating Station
Secretary, Nuclear Committee of the Board
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bcc w/encls:
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RI:DRSS	RI:DRSS	RI:DRSS	RI:DRSS
Eckert	Nimitz	Blasciak	Joyner
2/24/93	2/24/93	2/24/93	2/25/93

RI:DRSS	RI:DRSS
Shanbaman	Cooper
2/25/93	2/26/93

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