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REGION I

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Licensee:	PECO Energy Correspondence Control Desk P.O. Box 195 Wayne, Pa 19087-0195
Facility Name:	Limerick Generating Station, Units 1 and 2
Inspection Period:	September 19, through November 13, 1995
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EXECUTIVE SUMMARY
Limerick Generating Station
Report No. 95-18 & 95-18

Plant Operations

The inspectors concluded the Limerick LORT program was good. PECO senior operations and training managers were closely involved in the program and effectively addressed licensed operator feedback concerning the LORT program.

The annual operating examinations required the operators to safely and competently operate during normal, off normal and emergency situations. The inspectors concluded the scenarios overall were challenging and a very good examination. The performance standards used to evaluate the licensed operators, both individually and as a crew, were clearly stated. PECO evaluators conducted indepth evaluations of individual and crew performance. The inspectors concurred that a group of five individuals required remedial training before resuming licensed duties. Remedial training provided was effective in addressing individual needs when operator performance did not meet expectations. The program for maintaining an active license was found to have good controls and implementation.

The inspectors concluded the oversight by operations and training managers to be particularly effective and a strength of the requalification program. Also, operations management instituted prompt, effective corrective actions regarding a previous inspection finding on a procedure enhancement which had received ineffective initial corrective actions (section 1.3).

The inspectors concluded that the reactor engineering response to an instance where an administrative limit for total core flow was inadvertently deleted, once identified, was excellent. However, plant management needs to continue to stress the importance of having a questioning attitude concerning changing plant conditions and the affect on temporary procedure changes. While for this instance it was reactor engineering's responsibility to update the procedure, operations should question any change in an administrative limit that affects a reactivity control procedure (section 1.4).

No concerns were identified during a detailed walkdown of the Unit 2 standby liquid control system (section 1.5).

Maintenance

Corrective maintenance on a residual heat removal system check valve needed to be performed after backleakage was noted through the valve. Personnel noted that the disc nut had loosened and the nut retaining pin had backed out, due to inadequate staking of the nut, apparently causing the disc to cock and not seat properly. After the valve was restored, it continued to leak, caused by foreign material in the valve seat (section 2.1). At the end of this inspection period, plant personnel were conducting an investigation to determine why the valve nut was inadequately staked in May 1995, when it was modified, what the source of the foreign materials was in the valve, and why

the cleanliness inspection failed to identify the foreign materials. This item will remain unresolved pending NRC review of the completed investigation (URI 50-352/95-18-01).

The inspector concluded that a maintenance activity, to replace a current transducer associated with the Unit 1 main generator field temperature indication, was well planned and skillfully implemented (section 2.1).

The inspectors reviewed the current safety-related maintenance backlog and concluded that at that time it contained no single items or combination of items which would have an adverse effect on plant operations or affect system operability (section 2.2).

During this inspection period the inspectors performed a review of the control room deficiency tracking and trending program. The results of this review indicated that a substantial number of equipment trouble tags (approximately 100) were posted in the control room and not identified as control room deficiencies on the current list. At the end of the inspection period, engineering informed the inspectors that under a new engineering department initiative, Focus On Excellence Through People program, a new plan will be developed for the identification and tracking of these deficiencies. This plan is being developed with input from both operations and maintenance and will include a similar control room walkdown on an increased frequency to determine the effectiveness of the program. The inspectors will continue to review this issue during and after the implementation of the new program, which is expected to be in place by December 1995 (section 2.3).

Surveillance

Operators coordinated a reactor core isolation cooling system test with the health physics department to ensure that the appropriate plant areas were correctly posted as high radiation areas, in accordance with procedures. The inspectors noted good self-checking techniques during the performance of the test that included reading each step aloud and pointing to the controls before taking the action. The surveillance was completed satisfactorily (section 3.0).

Operators in the control room and the system manager were found to be very well prepared for performance of a high pressure coolant injection system surveillance. Additionally, the inspector noted that the procedure required appropriate testing of the differential pressure across the suppression pool suction strainer, as committed to by plant management in response to the clogged suction strainer event from September 1995 (section 3.0).

During an emergency diesel generator surveillance, the operator exhibited proper verification of equipment, and minimized distractions. The test was well coordinated with good support from operations personnel and management, and no problems were identified (section 3.0).

Engineering

The inspectors concluded that plant personnel made a good effort to determine the root causes and the time of the damage for a Unit 1 reactor core isolation cooling pump speed sensor. The inspectors walked down the Unit 1 RCIC system with engineering personnel to observe the current configuration on both units, and discussed the investigation of the event with the appropriate personnel. Additionally, the planned corrective actions were reviewed and appeared to properly address the root causes to prevent recurrence (section 4.1).

The inspectors concluded that after a high pressure coolant injection system steam line support bent rod was identified, plant engineering personnel made a conscious, deliberate decision to delay the repair to get additional data and to properly plan the repair. The rod broke prior to being replaced. Engineering personnel indicated that prior to the most recent failure the only data point of a similar failure was the one from last year. The recent failure provides another data point for additional consideration and learning. The inspectors concluded that the actions currently under way are appropriate to ensure that the final resolution is appropriate to ensure continued operability of the steam line support system (section 4.2).

On November 1, 1995, operations personnel identified that the Unit 2 Division 3 battery pilot cell was below the minimum voltage as required by technical specifications. After reviewing the procedures and discussing this issue with operations and engineering personnel, the inspectors concluded that no guidance was available for operators concerning actions to take when a pilot cell is found with a parameter below the technical specification value. As corrective actions for this issue, until better long term guidance is developed, operators will notify engineering personnel for actions to take to address a low voltage condition on any battery cell. Overall, the inspectors concluded that the actions taken were appropriate to address the concerns regarding battery cell voltage verifications (section 4.3).

Plant Support

NRC review found that the licensee developed and implemented a comprehensive plan to evaluate and enhance (as appropriate) the material and personnel contamination monitoring programs. Overall, the licensee's efforts were considered very good. Appropriate aspects of the programs were reviewed including instrument efficiencies, radionuclides present, and skin dose assessments. The licensee had yet to select a final counting efficiency for handheld friskers (section 5.1).

A core security inspection of the Limerick Security Program was conducted from September 25-28, 1995. The following areas were inspected: Audits; Corrective Actions and Management Support, Effectiveness of Management Controls; Security Program Plans; Protected Area Detection Systems; Alarm Stations and Communications, Testing Maintenance and Compensatory Measures and Security Training and Qualifications. It was determined that the licensee had an effective security program in place that was in compliance with the NRC-approved security plans and applicable regulatory requirements (section 5.2).

The licensee implemented a very good radiological environmental monitoring program and an effective meteorological monitoring program. However, lack of attention-to-detail in the meteorological monitoring program, regarding the commitment to submit analog strip charts to the consultant, was noted. The licensee's corrective action to this issue was appropriate (section 5.3).

Safety Assessment and Quality Verification

During the Limerick Nuclear Review Board meeting on November 10, 1995, the two presentations by site engineering personnel were well organized and provided valuable input for NRB consideration. The inspector concluded that the NRB adequately met its responsibilities as defined in the technical specifications (section 6.1).

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DETAILS

1.0 PLANT OPERATIONS (71001, 71707)[1]

The inspectors observed that plant equipment was operated and maintained safely and in conformance with license and regulatory requirements. Control room staffing met all requirements, and operators adhered to approved procedures. Operators were found alert, attentive and responded properly to annunciators and plant conditions. The inspectors reviewed control room logs for trends and activities, observed control room instrumentation for abnormalities, and verified compliance with technical specifications. Accessible areas of the plant were toured. Plant conditions, activities in progress, and housekeeping conditions were observed. Additionally, selected valves and breakers were verified to be aligned correctly. Deep backshift inspections were conducted on September 23, October 2, and November 4, 1995.

1.1 Operational Overview

At the beginning of the inspection period, Unit 1 was shut down due to the September 11, 1995, event where a safety relief valve (SRV) failed open. After five leaking SRVs were replaced and the suppression pool was cleaned, the plant was restarted on September 22, 1995. Full power was attained on September 27, 1995, after several chemistry hold points delayed power ascension, due to resin intrusion into the coolant system. Unit 1 remained at full power for the remainder of the inspection period, with minor exceptions for main turbine valve testing and control rod pattern adjustment.

Unit 2 operated at full power throughout the inspection period with minor exceptions for main turbine valve testing and control rod pattern adjustment.

1.2 Event Reports

There were no event reports during this inspection period.

1.3 Licensed Operator Requalification Training

During the week of September 25, 1995, the NRC conducted a performance-based inspection of the Limerick licensed operator requalification training (LORT) program using NRC Inspection Procedure 71001, Licensed Operator Requalification Program Evaluation.

Prior to the on-site inspection, the inspectors reviewed plant information, NRC inspection reports, licensee event reports (LERs), SALPs, and NRC Information Notices to see if special training was appropriate based on industry events, operator performance or plant modifications.

The inspection involved a review of the simulator portion of the annual operating tests and observation of operator and evaluator performance during the conduct of the test using the plant reference simulator. Interviews with training instructors, and supervisory personnel were conducted.

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[1]The NRC Inspection Procedures used as guidance are listed parenthetically throughout this report.

Administrative procedures and documents associated with the training program and its implementation were reviewed.

A review and assessment of the effectiveness of the training feedback process, remedial training program and management oversight were conducted. The inspectors also assessed conformance with license conditions associated with medical requirements, maintaining an active license, and participating in the requalification training program.

In addition to Inspection Procedure 71001 and NUREG-1021, Operator Licensing Examiner Standards, Revision 7, the inspectors used the Limerick administrative procedures as a basis for determining the adequacy of the PECO operator examination process.

1.3.1 Annual Operating Examinations

The annual operating examinations, composed of four simulator scenarios, were reviewed. The scenarios required the operators to safely and competently operate during normal, off normal and emergency situations. The inspectors concluded the scenarios overall were challenging and were a very good annual operating examination. The performance standards used to evaluate the licensed operators, both individually and as a crew, were clearly stated. In addition, the senior operations manager observed the examinations to assure that management expectations were met and reiterated to the crew following the examinations.

The examinations were administered to eight licensed operators that compose one operating crew of Limerick Units 1 and 2. The crew consists of four reactor operators, two shift supervisors, and one shift manager. The examinations were administered to a group of four individuals, two reactor operators, one shift supervisor and the shift manager. The inspectors observed the PECO Energy evaluators conducting the operating examinations.

Evaluations

Following the examinations, PECO Energy evaluators conducted indepth evaluations by the performance of the licensed operators and crews. Based on these evaluations, PECO Energy evaluators determined, and the NRC inspectors concurred, that a group of five individuals did not pass the annual operating examinations.

PECO Energy determined, and the inspectors concurred, that the unsatisfactory performance was based on two fundamental causes. First, the operators did not question improper directions given or actions taken by various crew members during critical events during the examinations. As a consequence, the proper procedural requirements during some normal, abnormal and emergency conditions were not successfully carried out by the crew. Secondly, the crew members did not communicate any information to each other during some critical events, and as a consequence, the opportunities for the crew to carry out the appropriate actions were missed. The licensed operators will receive remedial training and be reexamined prior to resuming licensed duties.

Examination Security

The inspectors reviewed the PECO Energy examination security controls for the operating tests. The inspector concluded that these controls were acceptable to provide for examination security and integrity.

1.3.2 Operator Feedback

The inspectors reviewed the feedback of the operators on the training conducted. The inspectors noted that the feedback was formally summarized and evaluated. Corrective actions were assigned using the plant information management system (PIMS). The training department also provided to the operators the resolutions to their comments. The feedback from the operators was detailed and indicated a generally high satisfaction level with the training received and a receptiveness on the part of management to respond to operator concerns and requests. Examples of training implemented as a result of feedback included electrical print reading, various specialized emergency operating procedures (EOP) training and simulator scenario training.

PECO Energy issued end-of-cycle training reports summarizing the results of each training segment conducted within the 2 year cycle. The reports partially summarized operator feedback and evaluated and trended training effectiveness with previous training segments. These reports were considered an excellent initiative and were one example that demonstrated effective management oversight of the LORT program.

1.3.3 Remedial Training

The inspectors reviewed the program requirements and actions taken by PECO Energy when operator performance did not meet expectations and concluded that the programmatic controls and the remedial training conducted were effective in addressing individual needs. Seven remediation packages as well as examination grades for the cycle were reviewed. The inspectors noted that examination performance had been generally good. In all cases remediation and retesting were completed prior to returning the licensed operators to on-shift duties.

1.3.4 Conformance to License Conditions

Active License

The inspector reviewed records of fifteen individuals that reactivated their licenses from an inactive status in the past two years. The records were complete and well maintained. The inspector concluded that all requirements were met to reactivate each operator's license to an active status.

Medical

The inspector reviewed a sample of twelve licensed operator medical files to ensure that medical examinations were being conducted biennially. The inspectors determined that physical examinations were performed biennially as required.

Participation in LORT

Attendance records were reviewed for the current two year training program. Records indicated attendance was good with no delinquent training beyond the previous training cycle (95-06) as permitted by PECO Energy's program requirements.

1.3.5 Management Oversight

The inspectors reviewed management oversight and involvement in the LORT program and concluded that management was effectively involved in a number of ways. The managers in training and operations met often and appeared to have a good working relationship. Senior operations representatives were involved in conducting simulator evaluations that provided feedback to the operators regarding management expectations. Management oversight visits evaluated simulator and class room training conducted and provided feedback on program effectiveness.

The inspectors noted that management was actively seeking out ways to improve the LORT program. For example, the development of the mentor program was a result of this activity. An instructor has been assigned to each crew to review their performance and provide feedback on their performance. The inspectors reviewed recent examples of simulator performance reports that have been developed as a result of the mentor program and concluded the operators were receiving detailed feedback on their individual and crew performance in an effort to provide training more customized to individual needs.

Another example of management initiatives was the 1995 LORT planning meeting held in November 1994. This meeting evaluated the success of the first half of the current two year training program and provided mid-cycle redirection for improving the training conducted during the second half of the cycle. A final example of management involvement was the 1996/1997 LORT planning questionnaire that was sent out to all licensed personnel to solicit their input for the next training cycle. The inspectors considered the questionnaire to be very well designed and was based on operator feedback received in the past year. The inspectors concluded that these examples demonstrated management's commitment to continued program improvements. The inspectors concluded the oversight by operations and training managers to be particularly effective and a strength of the requalification program.

Procedure Enhancement

NRC Inspection Report 50-352, 353/95-13 (August 1995) had identified that procedure SO6.1.C, Placing a Standby Reactor Feed Pump In Service, required a system pressure range that was inconsistent with plant conditions during a plant startup. PECO Energy had stated that the procedure would be revised in an appropriate manner.

The inspector determined during this inspection that the procedure had yet to be revised even though the plant had been operated in the startup mode. The inspector determined, based on discussions with PECO Energy personnel and documents reviewed, that the procedure change request had been requested using

the PPIS system (a longer term process) instead of the temporary change notice (TCN) process. PECO Energy immediately revised the procedure using the TCN process. Also, PECO Energy reviewed other procedures that were listed as PPIS changes to verify that an immediate TCN change was not required in any other instances. No other procedures were identified that required an immediate TCN and consequently, the inspector determined this to have been an isolated situation. Overall, the inspector concluded that despite the weak, initial corrective action approach, PECO Energy operations management had instituted prompt, effective corrective actions.

1.4 Unit 1 Administrative Limit on Core Flow

On October 19, 1995, while performing a main control room board walkdown, the inspector noted that Unit 1 reactor recirculation flow was approximately 101 mlb/hr. The inspector questioned the reactor operator and the shift supervisor about an administrative limit on core flow of less then 102 mlb/hr, to determine if they were familiar with the limit. This administrative limit had been put in General Procedure (GP)-5, Power Operations, as a temporary change (TC) as a corrective action following an event that occurred on July 19, 1995, when Unit 1 power increased to 103.4% of rated for 28 seconds following a recirculation pump transient (see NRC Combined Integrated Inspection Report Nos. 50-352/95-12 and 50-353/95-12). The operator and the shift supervisor stated that the limit of 102 mlb/hr was no longer in GP-5 and they believed the limit was 110 mlb/hr but could not say why the limit was removed.

In an effort to understand why the flow limit had been removed the inspector contacted reactor engineering, who informed the inspector that GP-5 was temporarily changed (TC'd) on July 24, 1995, to add the 102 mlb/hr flow limit and he was not aware of the limit being withdrawn. He also stated that he had just received a call from the control room operators asking similar questions about GP-5. Following an investigation by reactor engineering it was determined that the TC to GP-5 had an automatic 30 day expiration date based on expecting Unit 1 to be in a coastdown mode of operation within that time (the flow limit was only needed during normal full power operations). As a result of two mid-cycle outages in August and September of 1995, the Unit 1 coastdown was delayed and is not expected to begin until approximately November 30, 1995. The following day on October 20, 1995, reactor engineering TC'd GP-5 to include a flow limit of 105 mlb/hr corresponding to the electrical stop settings for the motor-generator (M-G) sets. The M-G set stops were reset to 106.6 mlb/hr during the mid-cycle outage to allow operation at 105 mlb/hr instead of the previous limit of 102 mlb/hr. The actual high speed electrical stop settings were also placed in system procedure (S)-43.0.C, as well as the expected indications for operation on an electrical stop. This limit will be in place on Unit 1 until the unit begins a coastdown at which time a special procedure, SP-147, will be put in place to raise core flow to 110 mlb/hr following the reset of the electrical and mechanical stops.

The inspectors concluded that the reactor engineering response to this issue, once identified, was excellent. However, plant management needs to continue to stress the importance of having a questioning attitude concerning changing

plant conditions and the affect on temporary procedure changes. While for this instance it was reactor engineering's responsibility to update the procedure, operations should question any change in an administrative limit that affects a reactivity control procedure.

1.5 Engineering Safety Feature System Walkdown

A system walkdown was performed on the Unit 2 standby liquid control (SLC) system. The inspector reviewed the current piping and instrumentation drawing (P&ID) and compared it to the actual plant condition. The alignment of valve position, identification, and general condition of the system were part of this walkdown. The portion of the system inside the drywell was not inspected during this walkdown.

All valves were aligned as depicted on the P&ID. Identification of the valves was clear and accurate. The SLC system appeared to be in good condition; however, a small amount of boric acid residue was present on the B SLC pump. The housekeeping around the system was acceptable. No concerns were identified during this inspection.

2.0 MAINTENANCE (62703)

2.1 Maintenance Observations

The inspectors reviewed the following safety-related maintenance activities to verify that repairs were made in accordance with approved procedures and in compliance with NRC regulations and recognized codes and standards. The inspectors also verified that the replacement parts and quality control used on the repairs were in compliance with PECO Energy's Quality Assurance (QA) program.

The following maintenance activities were reviewed:

- M-400-014, Revision 1, Preventive Maintenance Procedure For Q-Listed Type 1 Anchor Darling Bolted Bonnet Swing Check Valve With Test Levers and 2 Shaft Pins, performed November 7, 1995

On November 4, 1995, operators identified that the Unit 1 suppression pool level was increasing at a rate of approximately 15 gpm. Investigation revealed that the level increase was due to leakage through the B residual heat removal (RHR) pump discharge check valve. Operators verified that the safeguards keep-fill system could adequately keep up with the leakage. On November 6, 1995, investigation by engineering and maintenance personnel determined that there was unexpected movement in the valve when it was manually stroked; additionally, personnel could hear reverse flow through the valve, when thought to be closed. Later on November 6, operators observed that the suppression pool level was increasing quickly, at approximately 100 gpm. At this point operations verified that the safeguards keep-fill system could not adequately keep up with the increased leakage, and therefore declared the B RHR system inoperable. The check valve was disassembled on November 7, and it was discovered that the nut holding the disc onto the valve arm had loosened significantly. The pin which prevents the nut from backing

out had come out of the nut and was found near the nut. Plant personnel concluded that the nut, with the pin, was inadequately staked, which allowed the pin to back out, and subsequently for the nut to loosen. Since the valve disc was not tight against the arm, the disc became cocked, allowing leakage past the valve.

The valve in question is one of eight swing check valves (one per pump, and four pumps per unit), all on vertical runs of piping, and problems have been experienced in the past due to failure of the check valves to fully close after the pump is stopped. To increase the reliability of these valves, earlier this year a modification was initiated which entailed changing the hinge arm to shaft arrangement to permit operation of the disc independently of the shaft. Seven of the eight valves have been modified, and the remaining valve is scheduled to be modified before the end of the year. The purpose of the modification was not related to the leaking problem discussed here.

The inspector observed portions of the reassembly of the check valve on November 7. Maintenance personnel were very deliberate concerning staking the nut pin in place, and tried to punch the pin out after staking it. Prior to replacing the valve disc in the valve body, a quality verification for cleanliness was performed. After valve reassembly, the piping was filled and vented. It was then noted that there was still leakage through the check valve, so the valve was disassembled again, on November 8. A small piece of wood and a foam ear plug were found in the valve; the wood was holding the check valve partially open. The valve was inspected for potential damage, and the piping was examined between the valve and the pump to ensure that no other foreign material was present. At the end of this inspection period, plant personnel were conducting an investigation to determine why the valve nut was inadequately staked in May 1995, when it was modified, what the source of the foreign materials was in the valve, and why the cleanliness inspection failed to identify the foreign materials. Resolution of this item will remain unresolved pending NRC review of the completed investigation (URI 50-352/95-18-01).

- WO C0165754 (TI-M2-1FTI-1) Unit 1 Main Generator Field Temperature Alarm Transducer Replacement, performed on October 27, 1995.

The inspector observed a maintenance activity to replace a current transducer associated with the Unit 1 main generator field temperature indication. Control room indication for this instrument was reading high and the corresponding annunciator was in alarm. The inspector attended the pre-job briefing for the evolution that was held in the control room. Present for this meeting were representatives from operations, maintenance, and site engineering. Since this activity was being performed on-line, engineering ensured that operations was well aware of all indications and controls that were affected during this work. The potential for a plant transient was reviewed and safety precautions for the actual electrical work were discussed. Operations personnel suggested that the load dispatcher be informed of the work, and that a rubber pad be placed on the floor adjacent to the cabinet.

During the performance of the work a non-conductive blanket was draped on the generator field breaker, which was in the cabinet just below the current transducer that was being replaced. An equipment operator was present for the entire evolution and remained in contact with the control room at all times. The system manager also observed the replacement work. The inspector noted that appropriate safety measures were taken including the use of insulated tools, as well as a proper hard hat waiver. The two technicians performing the work were familiar with the job as they had walked down the activity the day before. Their actions in the cabinet were deliberate and efficient, completing the work in less than an hour. The inspector concluded that the activity was well planned and skillfully implemented.

2.2 Safety-Related Maintenance Backlog

During this inspection period, the inspectors reviewed a computer printout of the outstanding safety-related maintenance backlog. This review was performed to determine if there were any outstanding maintenance activities or combinations of activities which might have an adverse effect on plant operations or affect any system's operability. Based on this review, the inspectors concluded that the backlog of safety-related maintenance at this time contained no single items or combination of items which would have an adverse effect on plant operations or affect system operability.

2.3 Main Control Room Deficiencies

During this inspection period the inspectors performed a review of the control room deficiency tracking and trending program. Engineering is responsible for the program, and for coordinating activities with operations to ensure that deficiencies are identified, tracked, and corrected. As of November 1995, 69 deficiencies were identified and categorized as outage or non-outage, depending on when the repairs could be completed. In the past year the overall trend was slightly decreasing. The inspector requested a current list of deficiencies and performed a control room walkdown to cross reference the list to the actual equipment trouble tags (ETTs) in the control room. The results of this review indicated that a substantial number of ETTs (approximately 100) were posted in the control room and not identified as control room deficiencies on the current list. This review was discussed with engineering personnel and the inspectors were informed that coincident with this review, operations personnel performed a similar walkdown with identical results. These reviews indicated a fundamental problem with the tracking and trending program for control room deficiencies. While it was recognized that not all control room ETTs are control room deficiencies (they may indicate problems with equipment in the field or for operator information), the inspectors concluded that the discrepancy between the two lists needed to be reviewed. Without an actual baseline number of deficiencies, an accurate trend can not be developed.

At the end of the inspection period, engineering informed the inspectors that under a new engineering department initiative, Focus On Excellence Through People program, a new plan will be developed for the identification and tracking of these deficiencies. This plan is being developed with input from both operations and maintenance and will include a similar control room

walkdown on an increased frequency to determine the effectiveness of the program. The inspectors will continue to review this issue during and after the implementation of the new program, which is expected to be in place by December 1995.

3.0 SURVEILLANCE (61726)

During this inspection period, the inspectors reviewed in-progress surveillance testing and completed surveillance packages. The inspectors verified that the surveillances were completed according to PECO Energy approved procedures and plant technical specification requirements. The inspectors also verified that the instruments used were within calibration tolerance and that qualified technicians performed the surveillances.

The following surveillances were reviewed:

- ST-6-049-230-2, Revision 20, RCIC Pump, Valve and Flow Test, performed October 20, 1995.

For this surveillance activity, the inspectors observed the test from the main control room and locally in the reactor core isolation cooling (RCIC) room. The system manager was present in the control room for the test and assisted the operator in his review and performance of the test. The inspectors noted a considerable delay in the start of the test due to problems locating a calibrated suction pressure gauge and the associated fitting to connect it to the system. This issue was discussed with plant management from the standpoint of efficiency in the performance of the test, and will be reviewed for corrective action by the plant staff. The operators coordinated the test with the health physics department to ensure that the appropriate plant areas were correctly posted as high radiation areas, in accordance with procedures. The inspectors noted good self-checking techniques during the performance of the test that included reading each step aloud and pointing to the controls before taking the action. The surveillance was completed satisfactorily.

- ST-6-055-230-2, Revision 21, HPCI Pump, Valve and Flow Test, performed October 27, 1995

For this surveillance test, the inspector observed the preparations and setup for the testing from the main control room. A delay in the starting of the test was observed that was very similar to that mentioned above for the RCIC test of October 20, 1995. Operators in the control room and the system manager were found to be very well prepared for performance of this surveillance. Additionally, the inspector noted that the procedure required appropriate testing of the differential pressure across the suppression pool suction strainer, as committed to by plant management in response to the clogged suction strainer event from September 1995 (see NRC Combined Inspection Report 50-352, 353/95-81).

- ST-6-092-312-2, Revision 20, D22 Diesel Generator Slow Start Operability Test Run, performed November 8, 1995

The inspectors observed the monthly surveillance test for the D22 emergency diesel generator (EDG). Portions of the test observed included: pre-test clearances, communications, starting the EDG, bringing the EDG up to speed, electrically loading the generator and transferring electric loads from one bus to another. The EDG operated as expected, the start time and electrical loading was satisfactory.

A dedicated reactor operator (RO) was assigned to perform the surveillance test. The control room RO displayed effective communications with the equipment operator (EO) and the senior reactor operator (SRO). Before taking action, the RO verified the equipment by, pointing to the control switch, reading aloud the control switch number, verifying the number in the procedure and then operating the control switch. The RO minimized distractions from performing the test by limiting access to the area in the main control room associated with the diesel generators. The SRO questioned the RO to assure there were no distractions. The EO was kept informed during each stage of the test. The test was well coordinated with good support from the EO and management.

The inspectors performed a walkdown of the diesel generator, after the electrical loads were stabilized, to check for leaks and unexpected noises. Also, the tagout of valves and electrical breakers was verified. No problems were identified by the inspectors during the walkdown.

4.0 ENGINEERING (37551)

4.1 Broken RCIC Speed Sensor

On September 27, 1995, during a Unit 1 RCIC quarterly surveillance test, the pump tripped within seconds of being started due to a overspeed condition. Investigation determined that the condition was the result of a broken magnetic speed sensor on the turbine. The broken instrument caused a loss of feedback signal to the governor and a subsequent overspeed condition. The overspeed linkage was reset, the speed sensor was repaired, and the RCIC system was subsequently successfully run.

Initially, plant personnel believed that the speed sensor was damaged during an activity in August 1995, where insulation was replaced adjacent to and in front of the speed sensing line. However, further investigation, including interviews with the personnel performing the insulation installation, resulted in the conclusion that the speed sensor was not damaged as a result of that activity. However, plant personnel suspect that the insulation activity probably contributed to the failure in that it probably loosened the connection which ultimately broke when someone, at some later time, inadvertently stepped on the cable leading to the connection. Since the cable and connection were completely covered by insulation, someone stepping on and damaging the cable connection would not necessarily be aware of the damage done. Corrective actions planned included: removing some of the insulation which is not needed from around the cable, so that any damage would be easily detected; posting the area to alert personnel to the sensitive equipment which

could be damaged by inadvertently stepping on it; and evaluating the speed sensor cabling for modification to reconfigure it and make it less susceptible to damage.

The inspectors concluded that plant personnel made a good effort to determine the root causes and the time of the damage. The inspectors walked down the Unit 1 RCIC system with engineering personnel to observe the current configuration on both units, and discussed the investigation of the event with the appropriate personnel. Additionally, the planned corrective actions were reviewed and appeared to properly address the root causes to prevent recurrence.

4.2 Failed High Pressure Coolant Injection (HPCI) Trapeze Hanger Strut

On October 19, 1995, during a routine plant walkdown in the Unit 1 high pressure coolant injection (HPCI) area, the inspectors identified a bent rod on a steam line vertical trapeze hanger. The inspectors observed that the bent rod was at the same location as one that was identified as broken in November 1994. Plant engineering management determined that the cause of the failure in 1994 was low stress, high cycle fatigue. For the recent bent rod, engineering personnel inspected the hanger, and concluded that it was appropriate to repair the hanger at the next system outage, which was scheduled for late December 1995. This decision was based on the conclusion that: the nature of the previous failure did not support an imminent problem; the previous failure disposition concluded that the HPCI system was operable with the failed support; the support is the subject of a long term monitoring program because of the previous failure; and personnel thought it better to perform the maintenance using the normal planning process. Additionally, engineering personnel wanted to obtain vibration data on the steam line with the rod bent, without the support entirely, and with the repaired support.

However, on November 2, 1995, the support was found broken by personnel who were installing vibration monitoring equipment. The broken piece was sent out for testing, the piping was monitored for vibration without the hanger, the rest of the hanger was inspected with no other damage identified, and the hanger repair was completed on November 13, 1995. Additionally, all HPCI piping for both units was walked down and no other immediate concerns were identified concerning piping vibrations.

The inspectors concluded that after the bent rod was identified, plant engineering personnel made a conscious, deliberate decision to delay the repair to get additional data and to properly plan the repair. Engineering personnel indicated that prior to the most recent failure the only data point of a similar failure was the one from last year. The recent failure provides another data point for additional consideration and learning. The inspectors concluded that the actions currently under way are appropriate to ensure that the final resolution is appropriate to ensure continued operability of the steam line support system.

4.3 Failed Battery Pilot Cell

During a weekly surveillance test, on November 1, 1995, operations personnel identified that the Unit 2 Division 3 battery pilot cell was below the minimum voltage as required by technical specifications. Technical Specification Surveillance Requirement 4.8.2.1a.1. requires, in part, that the parameters in Table 4.8.2.1-1 meet the Category A limits. The Category A float voltage limit for each designated pilot cell is $\geq$ 2.13 volts. If the pilot cell voltage is outside the limit, the battery may be considered operable provided that within 24 hours all the Category B measurements are taken and found to be within their allowable values, and provided all Category A and B parameters are restored to within limits within the next 6 days. The allowable float voltage for each connected cell is $\geq$ 2.07 volts. On November 1, the pilot cell was measured as 2.06 volts.

Operators declared the battery inoperable and entered an eight hour technical specification action statement. The battery was then placed on an equalize charge. Approximately 2 hours later, the pilot cell voltage was measured as 2.072 volts, and the battery was declared operable. The battery charger was placed back in equalize, and operators continued monitoring the pilot cell voltage. Approximately 8 hours later the pilot cell voltage was found to be 2.042 volts, so the battery was again declared inoperable. The defective cell was replaced and the battery was declared operable within 8 hours. Additionally, all battery parameters were verified to be above the Category A values.

After reviewing the procedures and discussing this issue with operations and engineering personnel, the inspectors concluded that no guidance was available for operators concerning actions to take when a pilot cell is found with a parameter below the technical specification value. Engineering personnel contacted the battery vendor concerning this issue and found that although the actions taken on November 1 and 2, were acceptable, the best method for restoring the cell voltage is to use a single cell charger. As corrective actions for this issue, until better long term guidance is developed, operators will notify engineering personnel for actions to take to address a low voltage condition on any battery cell. Overall, the inspectors concluded that the actions taken were appropriate to address the concerns regarding battery cell voltage verifications.

5.0 PLANT SUPPORT (71750, 81700, 84750)

5.1 Radiological Protection

During the inspection period, the inspectors examined work in progress in both units including health physics (HP) procedures and controls, ALARA implementation, dosimetry and badging, protective clothing use, adherence to radiation work permit (RWP) requirements, radiation surveys, radiation protection instrument use, and handling of potentially contaminated equipment and materials.

The inspectors observed individuals generally frisking in accordance with HP procedures. A sampling of high radiation area doors was verified to be locked as required. Compliance with RWP requirements was reviewed during plant tours. People working in RWP areas were observed as meeting the applicable requirements.

5.1.1 Radioactive Material and Contamination Controls

On October 19, 1995, the inspectors met with PECO Energy radiological controls representatives to discuss enhancements planned and made in the area of contamination monitoring of material and personnel exiting radiological controlled areas (RCAs) of the station. The plans/enhancements were initiated as a result of identification of items of contaminated material outside the RCA and NRC questioning of the adequacy of radioactive contamination counting efficiencies of instrumentation used for contamination monitoring. (See NRC Combined Integrated Inspection Report Nos. 50-352/95-12; 50-353/95-12 for additional details.)

The inspectors' review indicated PECO Energy developed and implemented a comprehensive plan to evaluate the Limerick Station's radioactive material and contamination control programs. The plan included a detailed list of items for review and evaluation, assigned individuals for item evaluation, and expected item completion dates. Most actions were scheduled to be completed by the end of 1995. As part of the plan, the licensee evaluated the isotopic mix of radionuclides at various areas within the station, evaluated radioactive material and contaminated material monitoring instrumentation efficiencies, evaluated impacts on personnel skin dose assessments, and evaluated effective alarm set points of personnel and material contamination monitoring instrumentation. PECO Energy also lowered instrument alarm set points (as appropriate considering false alarm rates) and developed special calibration sources. PECO Energy was taking actions to place inservice in plant "hot" tool rooms to preclude repeated removal of tools from the RCA. HP management was continuing to evaluate the selection of an appropriate efficiency for handheld friskers. HP personnel plan to provide appropriate training of personnel on program changes. The inspector concluded that PECO Energy was aggressively evaluating the radioactive material and contamination monitoring programs for personnel and material exiting the RCA and making program enhancement changes, as appropriate.

During the inspection, the inspectors also discussed the plans for disposing of slightly contaminated settling pond sludge. PECO Energy was evaluating its disposal options at the time of the inspection. The sludge was properly stored.

No violations or safety concerns were noted.

5.2 Security

Selected aspects of plant physical security were reviewed during regular and backshift hours, to verify that controls were in accordance with the security plan and approved procedures. This review included the following security measures: guard staffing, vital and protected area barrier integrity, and

implementation of access controls including authorization, badging, escorting, and searches.

A regional based security inspector reviewed the security program during the week of September 25-28, 1995. The purpose of this inspection was to evaluate PECO Energy's compliance with NRC-approved Security Program Plans and applicable regulatory requirements.

5.2.1 Audits, Corrective Actions and Management Support

The inspector reviewed the report of the 1995 annual audit of the Security Program by QA conducted April 10 - May 17, 1995 (Audit No. A0921235).

The audit was found to have been conducted in accordance with the NRC-approved Security Plan (the Plan). The audit identified no findings, deviations or recommendations. The inspector's review concluded that the audit was comprehensive in scope, reported to the appropriate level of management and that the program was being properly administered. No corrective actions were necessary as a result of the QA audit; however, corrective actions implemented as a result of issues identified during self-assessments and other reviews were timely and effective.

Management Support

Management support for the security program was determined to be excellent. This determination was based on the inspector's review of various program enhancements which included installation of a biometrics access control system, upgrades and standardization of weapons, implementation of a tactical training program and ongoing refinements in defensive strategies.

5.2.2 Effectiveness of Management Controls

The inspector determined that the licensee had controls for identifying, resolving and preventing security program problems. These controls included the performance of quarterly self-assessments of their areas of responsibility by each security supervisor in addition to the required annual audit by QA. A review of documentation indicated that initiatives to minimize security performance errors and identifying and resolving potential weaknesses were being implemented. The initiatives in this area were considered to be effective.

5.2.3 Security Program Plans

PECO Energy made four changes to the Plan and one change to the Training and Qualification Plan since the last inspection November 7-10, 1994. The inspector verified that all the changes had been reported to the NRC in accordance with regulatory requirements and as implemented did not decrease the effectiveness of the plans.

5.2.4 Protected Area (PA) Detection System

The inspector physically inspected the PA intrusion detection system (IDS) on September 25, 1995, and determined by observation that the IDS was installed as committed to in the Plan. The inspector observed a scheduled quarterly testing of the IDS for a particular zone. The IDS tested 100 percent satisfactorily. Based on observations from alarm stations and the quarterly test, the inspector determined that the IDS was functional and met the commitments of the Plan.

5.2.5 Alarm Stations and Communications

The inspector observed Central Alarm Station (CAS) and Secondary Alarm Station (SAS) operations and verified that the alarm stations were equipped with the appropriate alarm, surveillance, and communication capabilities. Inspector interviews of CAS and SAS operators found them knowledgeable of their duties and responsibilities. The inspector also verified that the CAS and SAS operators were not required to engage in activities that would interfere with assessment and response functions and that PECO Energy had communications capabilities with the local law enforcement agencies as committed to in the Plan.

During the last inspection, three areas of assessment coverage were deemed to be marginal. PECO Energy implemented upgrades to the assessment system to enhance the assessment capability in these areas. The upgrades included the reconfiguration of some lighting and the installation of additional assessment aids. The inspector's review of the upgrades determined that they were effective.

5.2.6 Testing, Maintenance and Compensatory Measures

Testing and Maintenance

The inspector's review of testing and maintenance records for security-related equipment confirmed that the records committed to in the Plan were on file and that security personnel were testing and maintaining systems and equipment as committed to in the Plan. A review of these records indicated repairs are being completed in a timely manner and that a prioritization schedule is assigned to each work request.

Compensatory Measures

The inspector's review of the use of compensatory measures found them to be minimal, due to the efforts and prompt response of the maintenance group. The inspector's review of compensatory measures implemented on September 25, 1995 for degraded assessment capabilities due to inclement weather determined them to be in accordance with the Plan and to be effectively implemented.

5.2.7 Security Training and Qualification

The inspector selected at random and reviewed ten SPOs training, physical, and firearms qualification/requalification records. The inspector determined that the training had been conducted in accordance with the security training and qualification (T&Q) plan and that it was properly documented.

5.3 Radiological Environmental Monitoring Program

5.3.1 Management Controls

The inspector reviewed PECO Energy's organization for implementing the radiological environmental monitoring program (REMP) and the meteorological monitoring program (MMP), and discussed with the program responsibilities and changes made since the last inspection, conducted March 1994. In January 1994, Technical Services Branch at the Chesterbrook office, responsible for oversight of the REMP, had been eliminated. The responsibility had been transferred to the Programs Branch, Programs and Procedures Section. The inspector noted that the oversight of the REMP continued to be performed by the same personnel. Oversight of the MMP remained in the Programs Branch. As of March 1995, a System Engineer, Radiation Protection Department, became responsible for oversight of the MMP on site. The I&C Department had responsibility for calibrating and maintaining meteorological monitoring instrumentation.

5.3.2 Quality Assurance Audits

The inspector reviewed the following Nuclear Quality Assurance audits:

Report Number A0910170, NQA audit of Limerick/Peach Bottom REMP (March 27-April 26, 1995)

Report Number A0808561, NQA audit of Limerick/Peach Bottom REMP (March 30-April 26, 1994)

Report Number A0874922, Emergency Plan Procedures Assessment and 10 CFR 50.45(t) (September 19-October 14, 1995)

The audits had been conducted by members of Nuclear Quality Assurance and a technical specialist and covered the stated objectives of the audit scope for the REMP and the MMP. No items of safety significance were identified. The inspector noted that the audits were thorough and of sufficient technical depth to assess the REMP and MMP.

5.3.3 Annual Radiological Environmental Operating Report

The inspector reviewed the Annual Radiological Environmental Operating Report for 1993 and 1994, as well as the selected analytical data for 1995. The report provided a comprehensive summary of the results of the REMP around the Limerick site and met the technical specification (TS) reporting requirements.

The reviewed results indicated that all samples were collected and analyzed as required by the TS/ODCM. The reports were complete, and no obvious omissions or anomalous data were identified.

5.3.4 Direct Observations and Procedures

The inspector examined selected sampling stations to determine whether samples were being obtained from the locations designated in the TS/ODCM and whether air samplers were operable and calibrated. The sampling stations included air samplers for iodines and particulates, the composite water sampling stations located at the plant intake and other locations, vegetation locations, and thermoluminescent dosimeter (TLD) stations for measurement of direct ambient radiation. All air sampling equipment at the selected locations was operational at the time of the inspection, and the water compositors were operating and taking samples. The above environmental sampling media were available at the locations designated in the TS/ODCM, and TLDs were placed at locations designated in the TS/ODCM. The inspector also noted that personnel collected and analyzed more samples than required.

During the previous inspection, water compositors at Stations 13B1 and 16C2 were not operating. (See Combined Inspection Numbers 50-352/94-10 and 50-353/94-10 for details.) During this inspection, the inspector noted that both water compositors were operable. PECO Energy: (1) obtained a "right of way" permit from the state to obtain power to operate the water compositor at location 16C2, and (2) fixed the pipe in the river to achieve a continuous flow into the well that the compositor, at location 13B1, samples. Personnel cleaned the pipes, which lead to the compositor at the intake, of silt and will maintain this task yearly. In the intervals when the compositors were not operable, the inspector noted that grab samples were collected and analyzed according to the required frequency specified in the TS/ODCM. The inspector also noted that personnel used a portable water compositor to collect continuous water samples as compensatory action to lessen the burden of manual grab samples while the primary compositors were out of service.

The inspector reviewed the implementing procedures for the REMP. The procedures contained guidance for sample collection and preparation, analysis of environmental samples, and laboratory quality control. The inspector also reviewed the air sampler calibration procedure and records. Calibration of the vacuum gauges and orifices were performed according to the specified frequencies. All results of these calibrations were within the specified acceptance criteria. The inspector determined that the procedures provided sufficient guidance and instruction to ensure consistency and quality in the implementation of the REMP.

The inspector noted that the responsible individual in the Programs Branch developed and implemented performance indicators (PI) to assess the implementation of the REMP. The inspector reviewed the PI and noted that this helps to determine: (1) performance of the contractor, and (2) reliability of air samplers and water compositors. This appears to be effective in identifying weaknesses and strengths and improving any weaknesses, if determined. The development and implementation of performance indicators were

noteworthy and demonstrated effective self-assessment of the REMP. Based on the above review, the inspector determined that PECO Energy continued to effectively implement an excellent REMP.

5.3.5 Quality Assurance Program

The inspector reviewed the program for quality assurance (QA) of analytical measurements for radiological environmental samples. Beginning in January 1995, the primary contractor was GPU Environmental Radioactivity Laboratory (ERL). The ERL participated in an interlaboratory comparison (EPA cross-check) program required by TS. The inspector reviewed the results and noted that the results were within the acceptance criteria. The QC program consisted of measurements of duplicate and split samples. The inspector did not review the analytical results, because the ERL did not complete the quality control semiannual report by the time of this inspection. This will be reviewed during a subsequent inspection.

5.3.6 Meteorological Monitoring Program

The inspector examined the meteorological monitoring equipment calibration procedures and most recent calibration results to determine whether the instrumentation and equipment were operable, calibrated, and maintained. Members of the I&C department calibrate and maintain the sensors on the primary and secondary meteorological monitoring towers, including strip chart recorders in the control room. Calibrations were performed semiannually as required by TS/ODCM. All reviewed calibration results were within the defined acceptance criteria. The inspector determined that the calibration procedures contained sufficient guidance and instruction to perform calibrations of meteorological equipment effectively.

During the previous inspection, PECO Energy stated that the: (1) strip chart recorders in the equipment house at the primary and secondary towers would be replaced with patch panels into which personnel would have the capability to plug in a portable recorder and retrieve data, and (2) control room recorders would be replaced with a multi-point recorder by summer 1994. During this inspection, the inspector noted that the multi-point recorder in the control room was operable. The strip chart recorders located in the equipment houses at each tower had been retired in place but were not replaced with patch panels. PECO Energy conducted an engineering review and concluded that the recorders were not required. The inspector determined that this was acceptable and agreed with NRC Regulatory Guide 1.23, Meteorological Programs in Support of Nuclear Power Plants, September 1980.

The inspector noted that personnel identified problems with the reliability of the RM-21, the primary source of data retrieval. There had been periods of time when this resulted in loss of digital meteorological data; however, PECO Energy had two independent sources for retrieving data. PECO Energy stated that the responsible system engineer for meteorological oversight and the Nuclear Information Services Department (NIS) have been responsible for assessing and correcting the problems. NIS had been trending the performance of the RM-21 since June 1995. PECO Energy plans to upgrade the computer, if

necessary. The inspector concluded that PECO Energy had taken appropriate steps to resolve this issue and that progress in this area will be reviewed during a subsequent inspection.

This inspection identified a need for additional attention to detail in the meteorological monitoring program. The inspector reviewed procedure IC-11-00449, Check Procedure for the Limerick Meteorological System (Revision 2). The procedure did not provide sufficient guidance and instruction to adequately satisfy UFSAR, Section 2.3, commitments. PECO Energy had submitted to the environmental consultant analog strip charts, data logger print outs, and copies of the logbook monthly. The commitment, as stated in the UFSAR, Sections 2.3.3.2.2.2 and 2.3.3.2.2.3, is once per week. The lack of attention-to-detail resulted in a failure to comply with the above commitments. During this inspection, PECO Energy revised the procedure to reflect the UFSAR commitments. The inspector reviewed the procedure and determined that corrective actions were appropriate. The procedure will be reviewed during a subsequent inspection.

The inspector determined that the above concerns were not safety-significant issues and that PECO Energy continued to maintain an effective MMP.

6.0 SAFETY ASSESSMENT/QUALITY VERIFICATION (71707)

6.1 Nuclear Review Board (NRB) Meeting

The inspector attended the meeting of the Limerick Nuclear Review Board (NRB) on November 10, 1995. The inspector verified that the NRB reviewed those items required by the technical specifications, and that the composition and quorum requirements were met. Of particular note were the two presentations by site engineering personnel. The first concerned the inoperable hydrogen recombiners from August 1995, and the second concerned the SRV inadvertent lift event from September 1995. Both presentations were well organized and provided valuable input for NRB consideration. The inspector concluded that the NRB adequately met its responsibilities as defined in the technical specifications.

7.0 REVIEW OF LICENSEE EVENT AND ROUTINE REPORTS (90712, 90713)

7.1 Licensee Event Reports (LERs)

The inspectors routinely reviewed LERs and performed follow-up inspections to PECO Energy's actions regarding the disposition of corrective initiatives. The inspectors reviewed the following LERs and found that the events were described accurately, PECO Energy had identified the root causes, implemented appropriate corrective actions and made the required notifications.

LER 2-95-009, Corrosion Induced Bonding Results in Safety Relief Valve Setpoint Drift, Discovery Date: August 10, 1995, Report Date: September 9, 1995.

LER 2-95-010, Reactor SCRAM resulting from a High Reactor Vessel Pressure Signal Caused by a Malfunctioning Relay Associated with the Electrohydraulic Control System, Event Date: August 20, 1995, Report Date: September 19, 1995.

This event was reviewed in NRC Combined Integrated Inspection Report Nos. 50-352/95-12 and 50-353/95-12.

LER 1-95-005, Reactor Core Isolation Cooling (RCIC) System Isolation, and ESF Actuation, Due to a Water Flow Transient in the RCIC Steam Supply Line Caused by a Lack of Procedural Guidance, Event Date: August 27, 1995, Report Date: September 26, 1995.

This event was reviewed in NRC Combined Integrated Inspection Report Nos. 50-352/95-12 and 50-353/95-12.

LER 1-95-006, Unusual Event & RPS Actuation After the Reactor was Manually Shutdown due to a Leak Into the Primary Containment & Temporary Loss of the Normal Startup Level Control Valve, Event Date: August 28, 1995, Report Date: September 27, 1995.

This event was reviewed in NRC Combined Integrated Inspection Report Nos. 50-352/95-12 and 50-353/95-12.

LER 1-95-007, Tech Spec Condition Where the Unit 1 A & B and Unit 2 B Hydrogen Recombiners Were Inoperable due to an Inadequate Post-Mod Test Caused by Personnel Error, Event Date: September 2, 1995, Report Date: October 2, 1995.

This event was reviewed in NRC Combined Integrated Inspection Report Nos. 50-352/95-12 and 50-353/95-12, and resulted in a violation.

LER 1-95-008, Unusual Event and RPS Actuation When the Reactor was Manually Shutdown due to the Inadvertent Opening of a Main Steam Safety Relief Valve caused by Pilot Valve Seat Leakage, Event Date: September 11, 1995, Report Date: October 10, 1995.

This event was reviewed in NRC Combined Integrated Inspection Report Nos. 50-352/95-12 and 50-353/95-12.

LER 1-95-004, Revision 01, Actuations of the Unit 1 and Unit 2 PCRVICS resulting from a blown fuse when an I&C Technician inadvertently grounded a starter screwdriver, Event Date: July 28, 1995, Report Date: October 13, 1995.

Revision 00 of this LER was reviewed in NRC Combined Integrated Inspection Report Nos. 50-352/95-12 and 50-353/95-12. Revision 01 was submitted to correct an error in the time of the event.

LER 2-94-010, Revision 01, Reactor SCRAM and Actuation of Various Engineered Safety Features Resulting from a Relay Coil Failure and Inappropriate Action

By a Licensed Operator, Event Date: October 19, 1994, Report Date: October 13, 1995.

Revision 00 of this LER was reviewed in NRC Combined Integrated Inspection Report Nos. 50-352/94-24 and 50-353/94-24. Revision 01 was submitted to provide results of an analysis performed for the N-relay coil failure addressed in the report.

LER 2-95-009, Revision 01, Corrosion Induced Bonding Results in Safety Relief Valve Setpoint Drift, Discovery Date: August 10, 1995, Report Date: October 24, 1995.

Revision 00 of this LER was reviewed earlier in this section of the report. Revision 01 was submitted to correct an error concerning a serial number and another concerning an as-found setpoint.

The inspectors found that the LERs listed above met the requirements of 10 CFR 50.73 and had no further questions regarding these events.

7.2 Routine Reports

Routine reports submitted by PECO Energy were reviewed to verify the reported information. The following report was reviewed and satisfied the requirements for which it was reported.

> Station Monthly Operating Reports for August 1995, dated September 14, 1995 and September 1995, dated October 12, 1995.

8.0 MANAGEMENT MEETINGS

8.1 Exit Interviews

The inspectors discussed the issues in this report with PECO Energy representatives throughout the inspection period, and summarized the findings at an exit meeting with the Plant Manager, Mr. R. Boyce, on November 16, 1995. PECO Energy personnel did not express any disagreement with the inspection findings. No written inspection material was provided to licensee representatives during the inspection period.