January 9, 1997

Mr. D. M. Smith, President
PECO Nuclear
Nuclear Group Headquarters
Correspondence Control Desk
P. O. Box 195
Wayne, PA 19087-0195

SUBJECT: NRC INTEGRATED INSPECTION REPORT 50-352/96-09, 50-353/96-09; NOTICE OF VIOLATION

Dear Mr. Smith,

On October 22, 1996, through December 16, 1996, the NRC completed an inspection at your Limerick 1 & 2 reactor facilities. The enclosed report presents the results of that inspection.

During the 8-week period covered by this inspection period, your conduct of activities at the Limerick 1 & 2 facilities was generally characterized by safe and conservative operations. Operators responded appropriately to several plant transients. We noted that the material condition of the emergency diesel generators was significantly improved during this inspection period; however, it required the NRC pointing out the poor overall material condition to plant management before action was taken to correct this situation.

Our review of selected procedures and records and personnel interviews found the emergency preparedness program, overall, to be directed toward public health and safety. Noted strengths were management involvement, relationships with offsite agencies, and a well-defined self-assessment program.

The inspectors reviewed the applied radiological controls program including planning and preparation for the Unit 2 outage. The inspectors found that applied radiological controls were good including planning and preparation for the outage. However, weaknesses were identified in the control of radioactive sources.

Also reviewed was the disposal of radioactive material at the new 10 CFR 20.2002 disposal area. The area proposed for disposal of slightly contaminated flowable solids (soils, sediment, sludge) was found to be generally consistent with information provided to the NRC, but not in all material respects. Consequently, a violation involving failure to provide a complete description of the disposal area, as required by 10 CFR 50.9 and 10 CFR 20.2002, was identified. The violation is cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding it are described in detail in the subject inspection report. The violation is of concern because complete and accurate information was not provided prior to the NRC's approval of disposal of radioactive material in the environment. You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response.

NORTH AMERICAN INSPECTION, INC.

MEMO

December 12, 1996

TO: Robert K. Shumway, President

FROM: Don B. Shumway, RSO

As discussed during our meeting this date, you will assume all duties of the Radiation Safety Officer, during my absence. This will include my current medical leave, vacations, and regular scheduled days off.

Joel Guthrie - Operations Manager; manages lab services and schedules all work for NAII's radiographers. Also covers over 90% of all in-house radiography, with a small percentage of field-site radiography in emergency cases.

Now, the communication problem, as we see it. On August 7, 1996 NAII's RSO went on medical leave expecting to be out four to six weeks. Detailed instructions were given to the Assistant RSO by the RSO, as to when field audits were to be done, sources to be leak tested, and projectors needing quarterly maintenance to be administered, during his absence. Everything directed by the RSO was completed as instructed, but unfortunately the RSO developed complications, which extended his medical leave for over four months. On November 12 and 13, 1996, Sheri A. Arredondo and Eric Reber of your office conducted a routine safety inspection. The two radiographers not named on their "Notice of Violation" were the Assistant RSO and Operations Manager. Needless to say, as President of NAII I have asked myself many times, how could this have happened? During the absence of the RSO, his directives were reviewed with the Assistant RSO by me on a regular basis to assure all inspections were done as instructed. These two individuals' names were not on the original directive from the RSO. When the Assistant RSO was questioned as to why the Operations Manager was not picked up for a field audit, it was explained that the Operations Manager's work was mostly confined to the in-house lab service with most of this work being with X-ray machines, and that from a previous routine inspection conducted by the NRC's Kathleen Dolce on September 1, 1995, the RSO and Assistant RSO for NAII were told that in-house inspections and/or staged inspections outside the laboratory in the field were not acceptable. Also, on the day the Operations Manager was working in the field, which is the day picked up in this noted violation, the Assistant RSO was also working in the field and was unaware of the Operations Manager being out. The duties performed in the field by the Operations Manager on the day in question were to process film for the radiographer in charge of his project. The Operations Manager did not work with nor was he near the source of radiation during exposures on this day. The missed inspection on the Assistant RSO, during this same day, was due to the RSO not being back from his medical leave. The Assistant RSO assumed, that since he was the acting RSO and no one was over him at the time, that he would be exempted from a field inspection.

ACTION TAKEN TO PREVENT RECURRENCE

A subsequent meeting was held with the RSO, Assistant RSO, Operations Manager and myself on December 12, 1996. The above was discussed in detail and decided that until the RSO returns on a full-time basis, that the President will assume all duties as