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August 14, 1995

The Secretary of the Commission
U.S. Nuclear Regulatory Commission
Washington, DC 20555

ATTN: docketing and Service Branch

Re: Comment on Revision of NRC Enforcement Policy

Dear Secretary:

As reported in the Federal Register, Vol.60, No. 126, Friday, June 30, 1995, the NRC requested comments on Revision of NRC Enforcement Policy. The following comments concern part IV of the Notice, page 34385, on Severity of Violations, A. Aggregation of Violations and B. Repetitive Violations.

The experience of the Peach Bottom Atomic Power Station offers a good example of aggregation and repetition of violations. Enclosed is a list of 106 events, transients, weaknesses, failures, breakdowns and errors, including 2 Severity Level III Violations, 4 Severity Level IV Violations and 7 Notices of Violation, occurring between October 15, 1992 and May 24, 1995.

Reading through this list of 106 failures, a reasonable person could conclude several things: 1) such an aggregation of failures presents the possibility of combined or overlapping failures, resulting in greater severity failures; 2) many of the failures should have been termed violations; 3) several of the Notices of Violation should have been a higher severity level; 4) punitive fines should be assessed for all failures and violations; and 5) the NRC should define a threshold amount of failures and violations which would warrant shutting down the reactors for mechanical overhaul and personnel training.

This scandalous list of 106 failures in less than 3 years is not exceptional for Peach Bottom. A similar account of failures and violations is documented during the entire history of these reactors. Such performance is unacceptable and we protest the lenient regulation they have been accorded by the NRC.

The NRC's position that "several violations with a common cause may be more significant collectively" does not go far enough. The words "with a common cause" should be stricken. The cumulative effect, synergistic effect or simultaneous effect of multiple failures are definitely more significant collectively than

individually regardless if they have a common cause or not.

Moreover, repetitive failures or violations are significant even if they are not similar. While common cause and similarity of violations are significant, dissimilar but cumulative failures are also. The NRC should revise the enforcement policy to reduce the large number of failures at plants like Peach Bottom. The seriousness of possible catastrophe requires the strictest of regulation in the public interest.

How many failures will the NRC accept before fines and shutdowns are mandated: one hundred a year, one hundred a month, or no limit whatsoever, which is the current NRC policy?

What is the NRC's calculus of cumulative effect, synergistic effect or simultaneous effect of failures? What is the NRC's calculus of probability of accidents when multiple failures occur? Does the NRC have such formulae? If so, what are they? If not, why not?

Sincerely yours,

Richard Ochs

Richard Ochs,
Director

- October 15, 1992 - Unit-3 scrammed and recirculation pumps shutdown, "there was a significant cooldown in the bottom head as a result of the loss of forced circulation" (IR 50-277/94-04 and 50-278/94-04.)

- October 16, 1992 - The NRC identified programmatic weaknesses related to the System Manager program. (NRC IR 50-277/92-26 and 50-278/92-26.)

- November 16, 1992 - The NRC noted: "An industrial safety concern, which involved the potential for loss of power in the drywell...had not yet been resolved and warrants your attention" (NRC IR 50-277/92-30 and 50-278/92-30.)

- December 2 and 11, 1992 - Failures of the containment, atmospheric, dilution (CAD) system gas analyzer occurred at Unit-2. On both occasions PECO personnel did not "understand" or "recognize" the problem with the CAD. (NRC IR 50-277/92-29 and 50-278/92-29.)

- December 4, 1992 - Several weaknesses were reported during the the Initial SALP of Licensee Performance "including numerous component failures, lapses in the operating procedure and deficiencies in engineering and technical support" (York Daily Record, January 9, 1993.) "Among the areas identified for improvement were plant performance monitoring and engineering and technical support" (PECO, Report to the Shareholders, March 1, 1993.)

- December 7, 1992 - During Unit-2 start-up, the '2B' Recirculation Pump failed. (NRC IR 50-277/92-32 and 50-278/92-32.) (See March 2, 1993 for a related incident.)

- December 17, 1992 - Turbine control oscillations occurred while Unit-2 was operating at 89.5% power. The plant was "stabilized" at 76.5% power. (NRC IR 50-277/92-32 and 50-278/92-32.)

- December 19, 1992 - An Unusual Event was declared "due to a loss of emergency communications capabilities. Both units were operating at 20% power" (NRC IR 50-277/92-32 and 50-278/92-32.)

- January 1, 1993 - The Unit-2 high pressure coolant injection system was declared inoperable. (NRC IR 50-277/92-32 and 50-278/92-32.) (See January 25 and 31, March 1 and August 9, 1993, for related incidents.)

- January 21, 1993 - A Notice of Violation (NOV) was issued relating to the NRC's Motor-Operated Valve (MOV) Inspection on October 19-23 and November 3, 1992. PECO "1) did not document nonconforming positions, 2) did not properly disposition existing nonconforming conditions, and 3) did not take timely corrective actions to evaluate and resolve nonconforming conditions in MOVs..." (NRC IR 50-277/92-82; 50-278/92-82.)

- January 25, 1993 - During surveillance testing, the Unit-3 high pressure coolant injection system was declared inoperable. (NRC IR 50-277/93-01 and 50-278/93-01.) (See January 1 and 31, March 1 and August 9, 1993, for related incidents.)

- January 31, 1993 - The Unit-2 high pressure coolant injection system was declared inoperable. (NRC IR 50-277/93-01 and 50-278/93-01.) (See January 1 and 25, March 1, and August 9, 1993, for related incidents.)

- March 2, 1993 - Unit-2 scrammed while operating at 70% reactor power. (NRC IR 50-277/93-03 and 50-278/93-03.)

- March 2, 1993 - The Unit-2 '2A' reactor recirculation pump and '2A' condensate pump tripped while the Unit was operating at 100% power" (NRC IR 50-277/93-03 and 50-278/93-03.) (See December 7, 1992 for a related incident.)

- March 3, 1993 - The Unit-2 high pressure coolant injection system was declared inoperable. (NRC IR 50-277/93-03 and 50-278/93-01.) (See January 1, 25 and 31 and August 9, 1993 for related incidents.)

- March 7, 1993 - [R]eactor scram, due to a low reactor vessel level. Reactor feed pump trip while lowering reactor power to with in bypass valve capacity, to allow work on turbine valves" (IR 50-277/94-04 and 50-278/94-04.)

- March 10, 1993 - During a radiological safety inspection (February 8-9, 1993 and March 1-2, 1993), relating to a "breakdown of personnel access controls associated with the Transversing In-core Probe (TIP), the NRC found: "...control of personnel during such operations is considered very important as the TIPs represent one of the higher radiation sources that personnel have a potential for encountering" (NRC IR 50-277/93-02; 50-278/93-02.) (For related incidents see June 22 and 25, September 24, October 4, and November 11, 1993 and June 19 and November 29, 1994.)

March 23, 1993 - High oxygen concentration was found in Unit- 2 containment during power operation. (NRC IR 50-277/93-03 and 50-278/93-03.) (See January 17, 1992 for a related incident.)

- April 24, 1993 - Unit-2 was manually scrammed "following declaration of all reactor vessel level instrumentation served by the '2B' condensing chamber inoperable" (NRC IR 50-277/93-06 and 50-278/93-06.) (See related incident on March 27 and July 26, 1992 and September 22, 1993.)

- April 30, 1993 - A Notice of Violation was issued following an an NRC inspection of the electrical distribution system. Other design and operational weaknesses were identified relating to the emergency diesel generator. (NRC IR 50-277/93-80 and 50-278/93-80.)

- May 26, 1993 - Three individuals were found to be "inattentive" or "sleeping." (C. Anderson, NRC Region I.)

- June 22, 1993 - "Controls over a special high radiation area entry were not fully effective in that a higher than expected dose rate was identified upon the entry" (IR 50-277/94-04 and 50-278/94-04.) (See March 10, June 25, September 24 and October 4 and November 11, 1993 and January 19 and November 29, 1994.)

- June 24, 1993 - PECO discovered a "mispositioned" control rod at Unit-2. The reactor was operating at 60% power. (NRC IR 50-277/93-15 and 50-278/93-15.)

- June 25, 1993 "[U]unlock[ed] high radiation area door" (IR 50-277/94-04 and 50-278/94-04.) (See March 10, June 22, July 22, September 24, October 4 and November 11,1993 and January 19 and November 29, 1994.)

- July 4, 1993 - Unit 3 was shutdown. "An unplanned Unit 3 mid-cycle outage began on July 6, 1993, to replace to known leaking fuel bundles." A fuel leak was detected in May 1992. (NRC IR 50-277/93-15 and 50-278/93-15.)

- July 30, 1993 - Unit-3 was manually scrammed "after a loss of condenser vacuum" (NRC IR 50-277/93-15 and 50-278/93-15.)

- August 9, 1993 - The Unit-3 high pressure injection system was rendered inoperable (NRC IR 50-277/93-17 and 50-278/93-17.) (For related incidents see, January 1, 25 and 31 and March 1, 1993.)

- August 11, 1993 - Unit-2 was manually scrammed. (NRC IR 50-277/93-17 and 50-278/93-17.)

- August 14, 1993 - Unit-3 was shut down after three of four residual heat pumps were deemed inoperable. The plant was operating at 100% power. (NRC IR 50-277/93-17 and 50-278/93-17.)

- September 14, 1993 - The reactor feed pump tripped due to "flow oscillations" at Unit-3.

- September 16, 1993 - An inspection of Peach Bottom's Emergency preparedness program on June 28-30, 1993 found: "Significant areas for potential improvement included wind direction information use by emergency response groups, event announcements in the Emergency Operations Facility by the ERM [Emergency Response Manager], and ERM recognition of the best indication of main stack radiation" (NRC IR 50-277/93-10; 50-278/93-10.)

- September 22, 1993 - The NRC "noted that weaknesses in isolation of the reactor vessel water level instrumentation during installation of the [water level backfill]

modification resulted in the generation of a false low signal. This low label signal caused the ECCS initiation signals and entry into a technical specification required shutdown condition at Unit 3" (For related incidents see, March 27 and July 26, 1992 and April 24, 1993.) Also the NRC completed their investigation into the recirculation pump trip on July 27, 1992. (NRC IR 50-277/93-17 and 50-278/93-17.)

-September 24, 1993 - "Workers in Unit-3 were unaware of higher than expected radiation levels" (IR 50-277/94-04 and 50-278/94-04.) (See March 10, June 22 and 25, October 4 and November 11, 1993 and January 19 and November 29, 1994.)

- September 24, 1993 - "During core off load a fuel bundle became stuck partially inserted in its storage rack in the Unit 3 fuel pool..." (NRC IR 50-277/93-24 and 50-278/93-24.) (See February 21-22, 1993 for related events.)

- October 4, 1993 - An NRC inspection (August 2-6, 1993) found: "The lack of comprehensive corrective actions for some radiological discrepancies developed under the ROR [Radiological Occurrence Reporting] process was considered a significant radiological controls program weakness. A previous audit of the radiological controls program by the NQA [Nuclear Quality Assurance] identified a significant breakdown concerning radiological controls oversight. In particular, a weakness was noted in the area of radiation worker attention to detail and adherence to instructions provided by radiological controls staff" (NRC IR 50-277/93-19; 50-278/93-19.) (See March 10, June 22 and 25, October 4, September 24 and November 11, 1993 and January 19 and November 29, 1994.)

- October 6, 1993 - "[C]ontrol switch for control room emergency ventilation left in the off position following restoration" (IR 50-277/94-04 and 50-278/94-04.)

- November 11, 1993 "Unlocked high radiation door" (IR 50-277/94-04 and 50-278/94-04.) (See March 10, June 22 and 25, September 24 and October 4, 1993 and January 19 and November 29, 1994.)

- November 15, 1993 - "5th point heater valve out of position following Unit-3 start-up, leading to a steam leak to the turbine building" (IR 50-277/94-04 and 50-278/94-04.)

- November 22, 1993 - A Notice of Violation was issued for "a poor safety review of a temporary change to a reactor core isolation cooling testing procedure led to the inadvertent release of radioactive contamination within the Unit 3 reactor building. While this resulted in a minor clothing contamination, our review indicated poor management review and control of activities related to the specific testing" (NRC IR 50-277/93-24 and 50-278/93-24.)

- December 18, 1993 - "Missed continuous fire watch" (50-277/94-04 and 50-278/94-04.) (See related data on Thermo-Lag, September 29, 1994.)

- January 1 , 1994 - Philadelphia Electric Company changed its name to PECO Energy Company.

- January 19, 1994 - "During the inspection [October, 4-8 and November 8-10, 1993] the NRC reviewed the circumstances associated with three examples of failure by three different individuals to adhere to procedural requirements concerning entries to high radiation areas in two cases, and a respiratory protection required area in the third case." A Severity Level III violation was announced by the NRC.

"Particularly disturbing to the NRC is the fact that the plant equipment operator, on October 27, and the engineer on October 29, willfully violated the radiological controls in that they understood that they were no to enter the areas, yet did so anyway to complete certain tasks without first meeting the necessary radiation protection requirements. The entry by the engineer on October 29 was more significant since he had been warned by health physics personnel not to enter the area pending receipt of air activity results, yet did so anyway" (Thomas Martin, NRC, Regional Administrator, January 19, 1994.) (See March 10, June 22 and 24, September 24 and October 4, 1993 and November 29, 1994 for related incidents.)

- January 24, 1993 - The High-Pressure Coolant Injection system was declared inoperable in Unit-3.

- February 3, 1994 - Unit-3 was manually scrammed due to a Generator Field Ground alarm. The reactor was operating at 100% power.

- February 22, 1994 - During power restoration at Unit-2, a control rod (38-15) was mispositioned for approximately two minutes.

- February 23, 1994 - A jet pump grappling hook was dropped into the Unit-3 spent fuel pool.

- March 3, 1994 - Two four hour event notification reports were filed with the NRC due to the inoperability of the control room emergency system and problems associated with the Unit-2 high pressure coolant injection system. Both reports were later retracted.

- March 9, 1994 - Increased contamination was detected in the Unit-3 high pressure coolant injection, pump room. As a result, seven shoe contamination reports were filed.

- March 31, 1994 - A high-pressure coolant injection leak was identified.

- Spring 1994 - "The Public Utility Commission (PUC) recently approved a settlement with PECO Energy Company (PECO.) PECO will give $217,000 to a grant program for low income consumers and pay a $24,000 fine for violating PUC regulations. For 1991, the PUC found 241 violations of the Commission's regulations. Many had to do with PECO's handling of billing disputes and service shut-offs" ("Utility Consumer Line," Bureau of Public Liaison, PA PUC, Spring/Summer 1994.)

- April 18, 1994 - Further weld thinning was identified in the Emergency Service Water supply .

- April 27, 1994 - Unit-s experienced a reactor vessel water transient. "Pitting" was identified in this area in November 1993.

- May 14, 1994 - Power was reduced at Unit-2 to "approximately 77% to perform a rod pattern adjustment and to repair a non-safety main steam moisture separator drain tank (MSDT) drain valve. During the power restoration on May 16, the 2A reactor recirculation pump (RRP) speed increased unexpectedly, causing reactor power to increase above the average power range monitor flow biased high power scram setpoint, resulting in a reactor scram" (IR 50-277/94-06 and 50-278/94-06.)

- May 26, 1994 - A Severity Level IV violation was issued after the NRC "identified requirements for collecting a representative sample of the water river flowing into the site were not being met" (Edward C. Wenzinger, Chief, Projects Branch 2, Division of Reactor Projects, NRC.)

- June 16, 1994 - The NRC reported the following problems during Peach Bottom's most recent Radiological Emergency Preparedness Exercise: "...14 Areas Requiring Corrective Action (ARCA), two Planning Issues (PI), and eight Areas Recommended for Improvement (ARFI) were identified in the Commonwealth of Pennsylvania and the State of Maryland combined." (James Joyner, Chief, Facilities Radiological Safety and Safeguards Branch, NRC.)

June 22, 1994 - "PECO made four 10 CFR 50.72 four hour notification reports to the NRC during the period. Subsequently, PECO retracted three of the event reports" (IR 50-277/94-06 and 50-278/94-06.)

- June 23, 1994 - "The [NRC] inspectors continued to review the installation of the new control room radiation monitoring system...Specifically, system operating procedures were not in place when the system was placed in service and considered operable, the system was operated in an unanalyzed mode of operation because of unclear documentation, and one channel of the system was inadvertently removed from service due to the use of an improper drawing [A Notice of Violation was issued.]" Edward C. Wenzinger, Chief, Projects Branch 2, Division of Reactor Projects, NRC.)

- June 30, 1994 - "Two small surface cracks were found last September in welds on the core shroud of Peach Bottom Unit 3 near Delta., Pa., said Bill Jones, a spokesman for PECO Energy Co., the plant's operator...The shrouds are 2-inch thick stainless steel cylinders that direct the flow of radioactive water around the fuel core. A nuclear reaction boils water into the steam used to generate electricity" (The Patriot News, July 1, 1994 A5.)

A three-inch crack was identified in the reactor vessel shroud at Brunswick-1 in the summer of 1993. Cracks have also been found in the core-shrouds of Dresden-3 and Quad Cities-1. All of these reactors are GE Mark 1 designs.

- July 18, 1994 - A Severity Level IV Violation was issued for failure to implement maintenance procedures on the Unit-2 high pressure coolant injection system. PECO issued an LER.

- July 22, 1994 - "PECO identified that the existing instrument reference calibration placards were incorrectly installed with respect to the bottom of the torus of each unit" (IR 50-277/94-013 & 50-278/94-013.) PECO issued an LER.

- July 27, 1994 - An NRC inspection "noted that there had been no in-depth training provided to some of the [rad waste] shipping engineers since 1988...As such, the training provided to shipping engineers remains a program weakness. Licensee management informed the inspector they consider their current shipping engineer training program to be adequate" (IR 50-277/94-18 and 50-278/94-18.)

- August 3, 1994 - "...PECO Energy personnel unknowingly placed the emergency cooling water system in a configuration that prevented safety-related equipment from receiving design cooling water flow rates...The overall safety consequences of this event were small...however, this condition represented a significant degradation in plant safety..." An enforcement conference was held on October 18, 1994. (Richard W. Cooper, II, Director, Division of Reactor Projects, NRC, September 29, 1994.) (See November 21, 1994 for civil penalty and violation.)

- August 4, 1994 - PECO personnel missed a fire watch. (See August 10 and September 29, 1994 for related incidents.)

- August 10, 1994 - A "minor" fire was extinguished on the Unit-2 reactor building roof. During this episode, the Unit-2 secondary containment was breached.

- August 11, 1994 - The high-pressure, coolant-injection system was inoperable during maintenance activities. (See September 24, 1994 for related incident.)

- August 17, 1994 - "...procedures were not implemented for the operation of the reactor building [Unit-3] ventilation and standby gas treatment system" (PECO Energy, Gerald R. Rainey, Vice President, Peach Bottom Atomic Power Station, October 19, 1994.) A Severity Level IV Violation was issued.

- August 18, 1994 - An NOV was issued relating to vision problems of a LRO.

- August 26, 1994 - A NOV was issued relating to Motor Operated Valve Testing

- September 7, 1994 - A high-pressure, service water pump failed at Unit-3.

- September 8, 1994 - "Standard and Poor's Corporation (S&P) has revised its rating outlook on the company from 'negative" to stable'" (J.F. Paquette, Jr., Chairman of the Board and Chief Executive Officer.)

- September 20, 1994 - During the refueling outage, air bubbles were found leaking into the reactor cavity.

- September 21, 1994 - PECO notified the NRC of a loss of shutdown cooling at Unit-2 due to a preventive maintenance operation.

- September 23, 1994 - A broken fuel rod was discovered.

- September 24, 1994 - A high- pressure, coolant-injection steam supply leak was discovered at Unit 3. (See August 11, 1994 for related incident.)

- September 29, 1994 - "Thermal Science Inc. and its president, Rubin Feldman, were indicted September 29 by a federal grand jury on seven criminal charges, including willful violations of the Atomic Energy Act, a decade-long conspiracy to defraud the US government, false statements, and more. The charges are the culmination of a nearly two-year grand jury investigation of the company, which manufactures Thermo-Lag, the ineffective fire barrier used in more than 70 nuclear reactors [including Peach Bottom.]" (The Nuclear Monitor, October 17, 1994.) (See December 18, 1993.)

- October 10, 1994 - The NRC reported "four individuals entered the Unit 2 offgas pipe tunnel high radiation area (HRA), which was visibly posted as a HRA, and the individuals were not provided with the required radiation monitoring device, nor was positive control provided by an individual qualified in radiation protection procedures, nor did the individuals adhere to posted instructions regarding entry requirements, a requirement of the Radiation Work Permit under which the entry was made" (IR 50-277/95-05 and 50-278/95-05 and Notice of Violation.) (See October 31, 1994, November 29, 1994 and March 14, 1995 for related incidents and Notice of Violation.)

- October 16 -17, 1994 The Unit-2 reactor pressure vessel (RPV) exceeded 212 degrees F. "After reviewing operators' involvement in this event, Region I management initiated continuous coverage of the Unit-2 start-up, to ensure that operators performed a controiled and safe return of the unit to power operation" (Richard W. Cooper, II, Director, Division if Reactor Projects, November 21, 1994.) Severity Level IV Violations were issued.

- October 21, 1994 - FEMA assessed a Deficiency against the State of Maryland Emergency Operations Center for communications failure during the full-participation exercise on August 22, 1994.

- October 24, 1994 - A Licensee Event Report (LER) was filed for "Main Safety Relief and Safety Valve Setpoint Drift."

- October 27, 1994 - The DER reported that the "PECO inspection of the core shroud of Peach Bottom-2 did not find any significant flaws...Therefore, there is no repair needed for the time being." The NRC stated: "During the Unit 2 outage PECO conducted an ultrasonic inspection of the reactor vessel core shroud accessible weld areas. These examinations identified cracking of a similar nature found at Unit 3, but of much less magnitude. Based on an engineering analysis of the examination results, PECO determined that the Unit 2 shroud was structurally sound and that no actions were required to ensure its stability over the next operating cycle" (IR 50-277/94-21 & 50-278/94-21.)

- October 31, 1994 - The NRC reported "a Senior Reactor Operator (SRO) entered the Unit 2 high pressure coolant injection (HPCI) turbine room, which was visibly posted as a HRA, and the individual was not provided with the required alarming dosimeter, nor positive control provided by an individual qualified in radiation protection procedures, nor did the individuals adhere to posted instructions regarding entry requirements, a requirement of the Radiation Work Permit under which the entry was made" (IR 50-277/95-05 and 50-278/95-05 and Notice of Violation.) (See October 10, 1994, November 29, 1994 and March 14, 1995 for related incidents and a Notice of Violation.)

- November 10, 1994 - A LER was filed for "Non-Conservative Flow Biased Setpoints."

- November 18, 1994 - "A load drop to about 55% power occurred on November 18, 1994, to support cleaning of the main condenser waterboxes." Unit-2 returned to full power the following day. (IR 50-277/94-27 & 50-278/94-27.)

- November 21, 1994 - The NRC proposed a Severity Level III Violation and an $87,500 fine for the emergency service water configuration problem on August 3, 1994.

- November 21, 1994 - Three items of weakness were noted by an NRC Nondestructive Examination Laboratory Inspection: "these were not marking the weld centerline on welds for UT [ultrasonic inspection] as part of the ISI [inservice inspection] program, not finding or recording a geometric reflector in excess of 50% of DAC [distance amplitude correction] while conducting UT per the ASME [American Society of Mechanical Engineers] code on a RWCU [reactor water clean-up] system weld, and having radiographs that show signs of aging in storage for work performed after original construction" (IR 50-277/94-28 & 50-278/94-28.)

- November 29, 1994 - "Two separate events occurred, involving a total of five radiation workers, where personnel entered a high radiation area without having the required dose rate monitoring equipment. Individually, these events were of low radiological consequence; however, they reflect a continuing station weakness in personnel adherence to posted boundary requirements (Section 6.0). These events are considered an Unresolved Item (URI- 94-25-01) (IR 50-277/94-25 & 50-278/94-25.)

"While we recognize that you are aggressively taking actions* to prevent recurrence the events are similar in nature to other recent radiological events for which escalated enforcement action was taken" (Clifford J. Anderson, Section Chief, Projects Section 2B, Division of Reactor Projects.) (For related incidents see October 10 and 31, 1994 and March 14, 1995

*For similar events see March 10, June 22 and 25, September 24 and October 4, 1993 and January 19, 1994.

- December 9, 1994 - PECO made a four hour event notification after the utility discovered two doors that separate the main stack from the environment were left open for four hours.

- December 12, 1994 - PECO was among a consortium of 33 utilities actively pressuring the Mescalero Apaches to build a high-level radioactive waste dump on their land.

- December 19-23, 1994 - An inspector "identified a condition where manual operation of fire protection system controls located outside of the vital security areas could affect the operation of vital safety systems" (William H. Ruland, Chief, Electrical Section, Division of Reactor Safety, NRC, February 3, 1995.)

- December 20, 1994 - An NRC inspector determined there was poor control over the use of a non safety-related battery charger at Unit-2.

- December 22, 1994 - A steam/water discharge to the reactor building during reactor water cleanup system testing resulted in minor shoe contamination to three individuals and contamination in portions of the Unit-2 reactor building.

- January 7, 1995 - "Reactor power was reduced to below 75% [Unit 2]...to allow for the repair of a steam leak that developed from the stem packing of an outboard MSIV" (IR 50-277/95-10 and 50-278/95-01.)

- February 14, 1995 - A Violation was issued (Severity Level IV) for PECO's "failure to properly evaluate the installation, during outages in 1993, of 'temporary' shielding above each bank of hydraulic control units (HCU) at Units 2 and 3 (four locations total), which shielding is till in place...your staff's response, past and present, to questions about the shielding arrangements demonstrated a poor questioning attitude" (Clifford J. Anderson, Section Chief, Projects Section 2B, Division of Reactor Projects, NRC.)

March 1, 1995 - A High pressure Service Leak was identified by PECO at Unit-2.

March 6, 1995 - "...operational errors involving a mis-positioned valve, an inadequate valve position verification, and poor communications resulted in the loss of keep fill pressure on the 2B core spray (CS) sub-system [Unit 2.]" (IR 50-277/95-04 and 50-278/95-04.)

- March 14, 1995 - "However, based on the results of this inspection, certain of your activities were in violation of NRC requirements, as specified in the enclosed Notice of Violation (Notice). The violation is of concern and being cited because of the number of improper high radiation area entries which are described in the enclosed inspection report...in the most recent events, radiological control personnel failed to carry out their assigned duties in accordance with radiological control management's expectations; no similar causal factors were identified in the 1993 events.") (James H. Joyner, Facilities Radiological Safety and Safeguards Branch, Division of Radiation Safety and Safeguards, NRC.)

- March 17, 1995 - "An automatic recirculation pump runback reduced power [Unit-2] to about 70% on March 17, because of a mis-conducted reactor feed pump test." (IR 50-277/95-04 and 50-278/95-04.) The incident was caused by an operator error.

March 19, 1995 - High Pressure Coolant Injection (HPCI) suction valve was mispositioned at Unit-2 due to operator error. A Notice of Violation was issued. (Severity Level IV.) "Also, two subsequent shift turnover panel walkdowns failed to identify the abnormal system line-up and allowed the HPCI system to remain in the abnormal lineup for 18 hours." (Clifford J. Anderson, Section Chief, Projects Section 2B, Division of Reactor Projects.)

March 23, 1995 -Unit-3 was manually scrammed "after the air-operated main steam supply isolation valve to the 'B' steam jet air ejector (SJAE) failed closed causing a loss of condenser vacuum." (IR 50-277/95-08 & 50-278/95-08.)

April 10, 1995 - "The inspectors opened the three unresolved items pending review of your staff's assessment and planned corrective actions. The first issue addresses the possibility that, due to an equipment failure, a low pressure coolant injection sub-system (one of four) was not maintained with its piping full to prevent water hammer following an injection. The second issue deals with the secondary containment flood control portion of your emergency operating procedures, which could lead an operator to flood two emergency cool cooling pumps rooms, a condition outside the plant's design basis. Lastly, the third issue deals with inconsistencies between the standby liquid control system inservice testing methodology and ASME Section XI requirements for pump run time before operational data is requested." (Clifford J. Anderson, Section Chief, Projects Section 2B, Division of Reactor Projects.)

April 16, 1995 - All control rods were "conservatively" declared inoperable at Unit-2 for 4.5 hours.

April 21, 1995 - Control rod 46-07 "unexpectedly drifted" out of position at Unit-2. (IR 50-277/95-08 & 50-278/95-08.)

May 24, 1995 "...several events involving plant operators indicate a negative trend in plant operations performance. These instances include problems with procedural adherence, attention to detail, and control of maintenance activities." Executive Plant Performance Results, Richard W. Cooper, NRC, Director, Division of Reactor Projects.)