

April 12, 2002

Mr. John L. Skolds  
President and CNO  
Exelon Nuclear  
Exelon Generation Company, LLC  
4300 Winfield Road  
5<sup>th</sup> Floor  
Warrenville, IL 60555

SUBJECT: LIMERICK GENERATING STATION - NRC INSPECTION REPORT  
50-352/02-02, 50-353/02-02

Dear Mr. Skolds:

On March 30, 2002, the NRC completed an inspection at your Limerick Generating Station Units 1 and 2. The enclosed report documents the inspection findings which were discussed on April 3, 2002, with Mr. W. Levis and other members of your staff.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed procedures and records, observed activities, and interviewed personnel.

No findings of significance were identified.

Immediately following the terrorist attacks on the World Trade Center and the Pentagon, the NRC issued an advisory recommending that nuclear power plant licensees go to the highest level of security, and all promptly did so. With continued uncertainty about the possibility of additional terrorist activities, the Nation's nuclear power plants remain at the highest level of security and the NRC continues to monitor the situation. This advisory was followed by additional advisories, and although the specific actions are not releasable to the public, they generally include increased patrols, augmented security forces and capabilities, additional security posts, heightened coordination with law enforcement and military authorities, and more limited access of personnel and vehicles to the sites. The NRC has conducted various audits of your response to these advisories and your ability to respond to terrorist attacks with the capabilities of the current design basis threat (DBT). On February 25, 2002, the NRC issued an Order to all nuclear power plant licensees, requiring them to take certain additional interim compensatory measures to address the generalized high-level threat environment. With the issuance of the Order, we will evaluate Exelon's compliance with these interim requirements.

John L. Skolds

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Sincerely,

/RA/

Mohamed Shanbaky, Chief  
Projects Branch 4  
Division of Reactor Projects

Docket Nos.: 50-352; 50-353  
License Nos: NPF-39; NPF-85

Enclosure: Inspection Report 50-352/02-02, 50-353/02-02

Attachment 1: Supplemental Information

cc w/encl: Senior Vice President, Mid-Atlantic Regional Operating Group  
Senior Vice President - Nuclear Services  
Vice President - Mid-Atlantic Operations Support  
Chairman, Nuclear Review Board  
Director - Licensing, Mid-Atlantic Regional Operating Group  
Vice President - Licensing and Regulatory Affairs  
Site Vice President - Limerick Generating Station  
Plant Manager, Limerick Generating Station  
Regulatory Assurance Manager - Limerick  
Chief - Division of Nuclear Safety  
Secretary, Nuclear Committee of the Board  
Vice President, General Counsel and Secretary  
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U.S. NUCLEAR REGULATORY COMMISSION

REGION 1

Docket Nos: 50-352; 50-353

License Nos: NPF-39, NPF-85

Report No: 50-352/02-02, 50-353/02-02

Licensee: Exelon Generation Company, LLC

Facility: Limerick Generating Station, Units 1 & 2

Location: Evergreen and Sanatoga Roads  
Sanatoga, PA 19464

Dates: February 10, 2002 through March 30, 2002

Inspectors: A. Burritt, Senior Resident Inspector  
B. Welling, Acting Senior Resident Inspector  
C. Sisco, Operations Engineer  
R. Bhatia, Reactor Inspector  
M. Buckley, Resident Inspector, Peach Bottom  
J. Talieri, Reactor Engineer  
A. Lohmeier, Reactor Inspector  
H. Gray, Senior Reactor Inspector  
J. Noggle, Senior Radiation Specialist

Approved by: Mohamed Shanbaky, Chief  
Projects Branch 4  
Division of Reactor Projects

## SUMMARY OF FINDINGS

IR 05000352-02-02, IR 05000353-02-02; on 02/10-03/30/2002; Exelon Generation Company; Limerick Generating Station, Units 1 and 2; Resident Inspector Report.

This report was conducted by resident inspectors, regional reactor inspectors, an operations engineer, and a radiation specialist. The inspection identified no findings of significance.

The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at <http://www.nrc.gov/NRR/OVERSIGHT/ASSESS/index.html>.

### A. Inspector Identified Findings

No findings of significance were identified.

### B. Licensee Identified Violations

Violations of very low significance which were identified by the licensee have been reviewed by the inspector. Corrective actions taken or planned by the licensee appear reasonable. These violations are listed in section 40A7 of this report.

## Report Details

### Summary of Plant Status

Unit 1 began this inspection period operating at 94% power, in end-of-cycle coast down. On March 4, the unit was shut down for refueling outage 1R09. On March 19, the reactor was taken critical. The unit was returned to full power operation on March 28.

Unit 2 began this inspection period operating at 100% power and remained at or near that power level except for brief periods for planned testing and control rod pattern adjustments.

### 1. **REACTOR SAFETY** **Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity [Reactor - R]**

#### 1R04 Equipment Alignment (71111.04)

##### a. Inspection Scope

The inspector performed a partial system walkdown of accessible portions of the 1 'A' residual heat removal (RHR) system, while the 1 'B' RHR system was out of service for planned maintenance. The inspector used piping and instrumentation diagram 8031-M-51 and elementary diagram M-1-E11-1040-E015. The inspector reviewed the valve positions, major system components, electrical power availability, and equipment deficiencies.

The inspector also performed a partial system walkdown of the Unit 1 reactor core isolation cooling system, while the Unit 1 high pressure coolant injection system was inoperable. The inspectors used piping and instrumentation diagram 8031-M-49, and the walkdown included reviews of valve positions and equipment deficiencies. The inspector also referred to condition report (CR) 101009.

##### b. Findings

No findings of significance were identified.

#### 1R05 Fire Protection (71111.05)

##### a. Inspection Scope

The inspectors toured high risk areas at Limerick Unit 1 to assess Exelon's control of transient combustible material and ignition sources, fire detection and suppression capabilities, fire barriers, and any related compensatory measures. The inspectors reviewed the respective Pre-Fire Action Plan Procedures, surveillance testing results, frequency of these tests for selected detection and fire suppression components, and Section 9A of the Updated Final Safety Analysis Report (UFSAR). The following fire areas were inspected:

- Unit 1 'A' and 'C' RHR heat exchanger and pump room 102, elevation 177' (fire area 31)

- Unit 1 'B' and 'D' RHR heat exchanger and pump room 103, elevation 177' (fire area 32)
- D13 emergency diesel generator cell 1C (fire area 80)
- D14 emergency diesel generator cell 1D (fire area 82)
- D12 emergency diesel generator cell 1B (fire area 81)

b. Findings

No findings of significance were identified.

1R08 Inservice Inspection Activities (71111.08)

a. Inspection Scope

Activities inspected during refueling outage 1R09 included observations of ultrasonic testing (UT) in-progress and analysis of test results using the Geris and GE Smart 2000 UT systems. This included the areas of reactor vessel shell-to-shell weld BF, N2E Zone 2A inner radius of shell-to-nozzle H2C weld UT, and UT of N2E recirculation inlet nozzle-to-safe-end welds and core spray piping P3 and P6 welds. The in-vessel visual inspection findings on the jet pump riser-to-support weld RS9 were reviewed. Test data for several ultrasonic and visually identified indications were reviewed and confirmed to be evaluated by Exelon as part of the inservice inspection process.

The inspectors reviewed results of radiographic testing (RT) of circumferential pipe welds DCA-101-1FW2405 and DCB-102-1FW902 resulting from replacement of existing reactor water clean up system valves HV-044-1F001 and HV-044-1F004. The inspectors reviewed the GE Inspection Services Report for RT test procedure GE QCP-300 and test results, the acceptance standard ASME Section III 1992 NB5300 to which the radiographic indications were evaluated, the radiographic technique utilized, the weld process used Machine Gas Tungsten Arc Weld, the sensitivity of the radiographic method as shown by the penetrometer and densitometer measurement, the identification of the radiographer, and acceptance by the Level III data reviewer.

The inspectors reviewed action request A1359107 and work order C0200618 related to the evaluation and repair of a pinhole leak located at the pipe weld of emergency service water/residual heat removal service water including the apparent root cause and operability analysis. The inspectors verified that the repair procedure was in accordance with ASME XI, 1989 Edition, ASME III, 1983 Edition with Addenda through Summer 1983, ND-4453.1, and Code Case N-416-1 for pressure testing. The inspectors reviewed the nondestructive examination results of the repaired wall thicknesses.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)a. Inspection Scope

The inspectors reviewed Exelon's actions with respect to the Maintenance Rule for the following equipment performance problems:

- Unit 1 suppression pool cleanup pump trip
- D12 fuel oil transfer pump trip (maintenance preventable functional failure determination)
- Unit 1 reactor pressure indicator (PIS-042-1N678B) out of specification

The inspectors reviewed associated maintenance action requests (A1353879, A1351020, A1358057, and A1351113), condition reports (89513 and 90309), and Maintenance Rule expert panel 0203 minutes. Additionally, the inspectors discussed the issues, as needed, with system managers.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13)a. Inspection Scope

The inspectors reviewed Exelon's risk management and risk assessments as required by 10 CFR 50.65 (a)(4) of the following emergent and planned maintenance activities. The inspectors reviewed the Sentinel on-line risk assessment results, risk management activities, work control center planning and scheduling, and emergent work-related activities.

- 1 'C' reactor feed pump maintenance
- 1 'B' RHR check valve HV-051-1F041B indication problem
- 2 'B' RHR suppression pool suction valve (HV-051-2F004B) problem
- 'A' emergency service water system piping weld repair

Documents Reviewed

- condition report/PEP I0012894 - Limerick Generating Station risk assessments of on-line maintenance work less than adequate
- action requests A1318472, A0914652, A1358072; and TRT 02-0091
- surveillance test ST-4-051-307-2

b. Findings

No findings of significance were identified.

1R14 Personnel Performance Related to Non-routine Plant Evolutions and Events (71111.14)



a. Inspection Scope

The inspectors observed and reviewed licensed operator performance in the control room during the following non-routine events:

- Unit 1 'B' reactor feed pump manipulations. The operators were returning the 1 'B' reactor feed pump back to service after maintenance activities on February 15, 2002.
- Unit 1 reactor vessel hydrostatic test. The inspectors referred to procedures GP-10, Operational Hydrostatic Test, and GP-10 (COL-1), Equipment Alignment for Operational Hydrostatic Test.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)a. Inspection Scope

The inspectors reviewed technical adequacy of operability evaluations associated with the following plant equipment conditions:

- 1 'B' RHR inboard injection check valve (HV51-1F041B) indicates open (A1356855)
- 'A' emergency service water system leak (A1359107)
- 1'A' core spray full flow test valve failed to close (CR 91236)

The inspectors reviewed the applicable action requests, condition reports, and referred to Exelon procedure LS-AA-105, Operability Determinations.

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds (71111.16)a. Inspection Scope

The inspector reviewed selected operator workarounds to determine if the functional capability of affected systems or human reliability in responding to an initiating event was affected. The inspector evaluated the effect of the operator workarounds on operators' ability to implement abnormal or emergency operating procedures. In addition, the inspector reviewed selected equipment deficiencies to ascertain whether they constituted unevaluated operator workarounds.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing (71111.19)a. Inspection Scope

The inspectors observed post-maintenance testing and reviewed the test data for the following:

- high pressure coolant injection barometric condenser condensate pump thermal overload post-maintenance testing
- D12 4 KV bus post maintenance testing (examination, cleaning, and lubricating of Q listed breakers)
- Unit 1 high pressure coolant injection valve HV-055-1F002 stroke time test
- Unit 1 reactor vessel operational hydrostatic test

Documents Reviewed

Engineering change request (ECR) 99-02528  
 WO C0192545  
 WO R0769303  
 A1360465  
 GE Failure Mode Analysis DRF No. E41-0045(B)  
 WO R0841710  
 PM 255020  
 PM 232479

b. Findings

No findings of significance were identified.

1R20 Refueling and Outage Activities (71111.20)a. Inspection Scope

The inspectors observed and/or reviewed numerous Unit 1 refueling outage 1R09 activities and controls, including:

- Plant shutdown and cool down activities
- Outage risk management, including changes due to emergent work or unexpected conditions
- Outage configuration controls including:
  - 1) availability and accuracy of reactor coolant system instrumentation
  - 2) electrical power alignments
  - 3) decay heat removal system operation
  - 4) availability of reactor inventory makeup water systems
  - 5) secondary containment controls and integrity
- Fuel handling operations, including fuel movement, fuel assembly tracking, and core verification activities.

- Reactor startup, including system restoration, preparation for reactor mode changes, control rod withdrawal, reactor criticality, reactor coolant system heat up, and reactor power increases.

During the conduct of the refueling inspection activities the inspector reviewed the associated documentation to ensure that the tasks were performed safely and in accordance with plant technical specifications and operating procedures. The procedures reviewed included the following:

- GP-2, Normal Plant Startup
- GP-3, Normal Plant Shutdown
- GP-3, Appendix 1, Establishing Cold Shutdown
- GP-6.1, Shutdown Operations - Refueling, Core Alteration and Core Off-Loading
- GP-6.2, Shutdown Operations - Shutdown Condition Tech Spec Actions

Prior to the commencement of the reactor startup, the inspector also performed a walkdown of the drywell and selected Unit 1 structures, systems and components (SSCs) to assess the readiness of the SSCs to support plant restart following the refueling outage.

b. Findings

No findings of significance were identified.

1R21 Safety System Design and Performance Capability (71111.21)

a. Inspection Scope

(Closed) Unresolved Item 50-353/01-07-02 Analysis of impact of Agastat relay failure on High Pressure Coolant Injection (HPCI) and Anticipated Transient Without Scram (ATWS) Design Flows

During the NRC Safety System Design and Performance Capability team inspection, the NRC questioned the adequacy of Exelon's evaluation of the failure of the feedwater injection valve (HV-055-2F105) to open during the surveillance testing on April 17, 2001. Exelon's evaluation did not contain an objective or quantitative basis for determining that the reduced HPCI system total flow would have been adequate to perform its safety function. This evaluation also did not address the effect of the increased HPCI system flow through the core spray system on an ATWS event. This issue was left as an unresolved item.

The inspector reviewed the licensee's subsequent engineering analysis (LEAM-0008) of January 23, 2002, and attachment to ECR LG 01-01152, which indicated that although the HPCI system was in a degraded condition it was capable of performing its intended safety function and would have a negligible impact on an ATWS event.

The inspector reviewed the above analyses results and verified that the assumptions in the calculations were reasonable. The inspector also verified the HPCI discharge pressure and flow data in the last surveillance test (ST-6-055-230-2) conducted on

December 19, 2001, and found it consistent with the assumptions. The inspector identified no other issues. Based on this review, the inspector concluded that the licensee had adequately addressed the above concerns. This unresolved item is closed.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors reviewed and observed portions of following surveillance tests, and compared test data with established acceptance criteria to verify the systems demonstrated the capability of performing the intended safety functions. The inspectors also verified that the systems and components maintained operational readiness, met applicable Technical Specification requirements, and were capable of performing the design basis functions. The observed or reviewed surveillance tests included:

- ST-6-051-202-1, A RHR Cold Shutdown Valve Test
- ST-6-092-314-1, D14 Diesel Generator Slow Start Operability Test Run
- ST-4-095-963-1, Division II Safeguard Battery Charger 24 month Load Test
- ST-6-092-116-1, D12 Emergency Diesel Generator 4 KV Loss of Power LSF/SAA and Outage Testing)
- ST-6-092-115-1, D11 LOCA/LOOP Test, Emergency Diesel Generator 4 KV Loss of Power LSF/SAA and Outage Testing

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors reviewed temporary power provided to various plant equipment for an outage of the D12 safeguard bus during refueling outage 1R09. The inspectors referred to RT-6-092-452-1, "Procedure for De-energizing and re-energizing the D12 Safeguard Bus During a Refuel Outage."

b. Findings

No findings of significance were identified.

**2. RADIATION SAFETY**

**Cornerstone: Occupational Radiation Safety [OS]**

2OS1 Access Controls to Radiologically Significant Areas (71121.01)

a. Inspection Scope

The inspector reviewed the access control program (as required under Plant Technical Specifications and 10 CFR 20.1601) by examining the controls established for exposure significant areas, including postings, barricades, locking controls, radiological briefings, and radiation protection technician coverage of workers was observed relative to access to radiologically significant areas. In-plant areas and activities reviewed included: drywell access to high radiation areas, transverse in-core probe room access to a locked high radiation area, reactor building 283 foot elevation reactor water cleanup (RWCU) access to high radiation areas, and refueling floor radiological controls. For each of these areas, radiation surveys, radiation work permit controls, and electronic dosimeter alarm set-points were reviewed with respect to technical specification requirements. The content, criteria, and qualification matrix documentation for contractor health physics technician training for the Unit 1 outage was also reviewed. Condition reports assigned to the radiation protection group since the beginning of the refueling outage were reviewed (8).

b. Findings

No findings of significance were identified.

2OS2 ALARA Planning and Controls (71121.02)

a. Inspection Scope

The inspector reviewed Exelon's ALARA performance in accordance with 10 CFR 20.1101(b). Areas reviewed included an evaluation of ALARA planning for the highest exposure outage tasks: drywell in-service inspection, drywell piping insulation, drywell scaffolding, drywell undervessel activities, drywell main safety relief valve replacement, reactor water cleanup inboard and outboard isolation valve replacements, and refueling floor activities. The outage work in-progress observations and reviews included:

- drywell insulation and scaffolding changes over a 4-day period;
- observations in the drywell of reactor water cleanup inboard isolation valve replacement;
- main safety relief valve replacement activities;
- observations on the refueling floor of fuel replacement activities;
- observations in the RWCU room of outboard isolation 004 valve replacement activities;
- independent radiation surveys of the drywell and reactor building safeguards rooms;
- independent shielding evaluations of the drywell;
- observation of closed circuit television equipment use in the drywell and interviews with drywell radiological engineering staff were conducted with respect to drywell remote health physics coverage capability.

b. Findings

No findings of significance were identified.

**Cornerstone: Public Radiation Safety [PS]**

2PS1 Radioactive Gaseous and Liquid Effluent Treatment and Monitoring Systems

a. Inspection Scope

The inspector reviewed condition report 95809 involving a Unit 2 condensate storage tank leak path to the holding pond and subsequent river discharges that occurred between February 14-21, 2002. This included a review of the release circumstances, release volumes, applicable tritium concentrations with respect to EPA drinking water limits and NRC regulatory requirements, daily sampling of this release pathway for radioactivity release, and offsite dose calculations with respect to the regulatory limits specified in the licensee's offsite dose calculation manual relative to methodology and reporting requirements. The inspectors verified that the tritium concentrations were below the EPA drinking water criteria and without discernable postulated offsite dose.

b. Findings

No findings of significance were identified.

**4. OTHER ACTIVITIES [OA]**

4OA1 Performance Indicator Verification (71151)

.1 (Closed) Unresolved Item 50-353/01-12-01 Evaluation of reduced high pressure coolant injection flow on the high pressure coolant injection unavailability performance indicator

a. Inspection Scope

During NRC review of the accuracy and completeness of supporting data for the Limerick HPCI unavailability performance indicator (July 2000 to June 2001), the inspector was not able to complete the determination of the accuracy of this performance indicator because of the licensee's ongoing evaluation of this degraded system condition. This item was left unresolved pending Exelon completion of this evaluation and further review by the inspector.

The inspector reviewed the licensee's engineering analysis (LEAM-0008) of January 23, 2002, and attachment to ECR LG 01-01152, which indicated that although the HPCI system was in a degraded condition it was capable of performing its intended safety function. Based on this outcome, the inspector concluded that the existing HPCI unavailability performance indicator data is accurate and complete. This item is closed.

b. Findings

No findings of significance were identified.

## .2 Physical Protection Performance Indicators Review

### a. Inspection Scope

The inspector reviewed Exelon's programs for gathering and submitting data for the Fitness-for-Duty, Personnel Screening, and Protected Area Security Equipment Performance Indicators. The review included Exelon's tracking and trending reports, personnel interviews, and security event reports for the Performance Indicator data collected from January 2001 through December 2001.

### b. Findings

No findings of significance were identified.

## 4OA3 Event Followup (71153)

### .1 Radioactive Waste Sent to Local Landfill

#### a. Inspection Scope

On March 11, 2002, officials at the Pottstown, PA, landfill notified the Pennsylvania Department of Environmental Protection (DEP) and Limerick Generating Station that five plastic bags labeled as radioactive trash were discovered at the landfill. DEP personnel and Limerick health physics technicians responded to the landfill. The DEP staff performed independent radiological surveys and measurements at the landfill and of the bags. DEP determined that the materials inside of the five bags were slightly contaminated with a gamma emitting isotope of cobalt (cobalt-60). The DEP survey and measurements were consistent with those later performed by Exelon and with the NRC inspector's assessment.

The technicians returned the bags to Limerick, determined that all bags were intact, and measured very low levels of radioactivity from the bags. The highest dose rate from the bags measured by Exelon was approximately 0.5 mrem/hr on contact. The technicians also performed detailed analyses of the contents, recording bag weights, types of materials, activity levels, and dose rates.

The inspectors observed the return of the bags to the station, inspected the contents of the bags, followed selected aspects of Exelon's preliminary investigation, and discussed the progress of the investigation with health physics managers and staff. Exelon determined that the bags contained material from their offsite licensed laundry service that was returned to the Limerick Station for disposal. A contract employee, without the proper supervision, placed the bags in a dumpster that was for non-radioactive material only, contrary to Exelon's established procedures. As regular trash, the contents of this dumpster were hauled to the landfill where the five bags were discovered. Exelon initiated a number of interim corrective actions, including surveying of all dumpsters leaving Limerick Station, conducting routine walkdowns of dumpsters, and changing the laundry trash receipt process.

Additionally, the inspectors met with DEP representatives, independently walked down the laundry trash receipt process, observed activities in the radwaste enclosure area, and inspected the trash dumpster area.

b. Findings

Exelon sent five bags that contained radioactive material to the Pottstown, PA landfill, contrary to Exelon's established procedures. Exelon has entered this issue into their corrective action program as condition report 98759. This item will remain unresolved pending completion of Exelon's investigation and a subsequent inspection by an NRC radiation specialist. **(URI 50-352;353/02-02-01)**

40A6 Meetings, Including Exit

.1 Exit Meetings

The inspectors presented the inspection results to Mr. Levis and other members of station management on April 3, 2002.

The regional radiation specialist presented the results of the Occupational Radiation Safety inspection to members of station management and staff at the conclusion of the inspection on March 14, 2002. The inspectors asked Exelon whether any materials examined during the inspections should be considered proprietary. No proprietary information was identified.

Regional reactor inspectors presented the In-service Inspection Activities inspection results to members of station management and licensee staff, at the conclusion of the inspection on March 14, 2002. The lead inspector asked the licensee whether any materials examined during the inspection should be considered proprietary. Some proprietary items were reviewed and returned during the inspection, but no proprietary information is presented in this report.

.2 Annual Assessment of Safety Performance

On March 26, 2002, the NRC met with Exelon, in the Limerick Energy Information Center in Linfield, PA, to discuss the NRC's annual assessment of the safety performance of the Limerick Generating Station. The meeting was open to the public. A copy of the slides can be found in ADAMS (Ascension Number ML020870172).

40A7 Licensee Identified Violations

The following findings of very low significance (Green) were identified by Exelon and are violations of NRC requirements which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as Non-Cited Violations (NCVs).

NCV Tracking Number

Requirement Licensee Failed to Meet



- NCV 50-352/02-02-02      Technical Specification 3.0.4 states that entry into an Operational Condition shall not be made when the conditions for the Limiting Condition for Operation are not met and the associated Action requires a shutdown if they are not met within a specified time interval. Contrary to the above, on or about March 19, 2002, Unit 1 entered Operational Condition 2 (startup), with the Division II DC Battery Charger 1B1D103 inoperable due to an unsatisfactory surveillance test, a condition that requires a shutdown. This item is documented in the licensee corrective action program as CR 100013. This is being treated as a Non-Cited Violation.
- NCV 50-352/02-02-03      Technical Specification 3.8.2.2 requires that two of the four divisions of DC power be operable in Operational Conditions 4, 5, and \*. Contrary to the above, during the period March 14 through March 17, 2002, while in refueling outage 1R09, the Unit 1 DC Power Divisions I, II and III were inoperable concurrently. This condition occurred due to an unsatisfactory surveillance test and lack of supervisory review. This item is documented in the licensee corrective action program as CR 100013. This is being treated as a Non-Cited Violation.

If you deny these Non-Cited violations, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Limerick Facility.

## ATTACHMENT 1 - SUPPLEMENTAL INFORMATION

a. Key Points of ContactExelon Generation Company

R. Braun	Plant Manager
E. Callan	Director - Maintenance
W. Harris	Radiation Protection Manager
W. Levis	Site Vice President
C. Mudrick	Director - Engineering
W. O'Malley	Director - Operations
J. Stone	Director - Outage Management
J. Tucker	Senior Manager - Plant Engineering

b. List of Items Opened, Closed, and DiscussedOpened

URI 50-352;353/02-02-01      Radioactive waste sent to local landfill

Closed

URI 50-353/01-12-01      Evaluation of reduced high pressure coolant injection flow on the high pressure coolant injection unavailability performance indicator

URI 50-353/01-07-02      Analysis of impact of Agastat relay failure on high pressure coolant injection and anticipated transient without scram design flows

Opened and Closed

NCV 50-352/02-02-02      Failure to meet TS 3.0.4 due to a change in Operational Conditions with unsatisfactory results on a Unit 1 Division II battery charger surveillance test.

NCV 50-352/02-02-03      Failure to meet TS 3.8.2.2 due to unsatisfactory results on a Unit 1 Division II battery charger surveillance test, with two other DC Power divisions inoperable during a refueling outage.

c. List of Acronyms

ALARA	As Low As is Reasonably Achievable
AR	action request
ATWS	anticipated transient without scram
CFR	Code of Federal Regulations
CR	Condition Report
DEP	Department of Environmental Protection
DBT	Design Basis Threat
ECR	Engineering Change Request
ESW	emergency service water
HPCI	high pressure coolant injection
LGS	Limerick Generating Station
LOCA	loss of coolant accident
LOOP	loss of offsite power
NCV	non-cited violation
NRC	Nuclear Regulatory Commission
PI	performance indicator
RHR	residual heat removal
RT	radiographic testing
RWCU	reactor water clean-up
SDP	significance determination process
SSC	structures, systems and components
UFSAR	Updated Final Safety Analysis Report
UT	ultrasonic testing