September 29, 1999

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

SUBJECT: MID-CYCLE PLANT PERFORMANCE REVIEW (PPR) - PEACH BOTTOM ATOMIC POWER STATION

On September 13, 1999, the NRC staff completed the mid-cycle Plant Performance Review (PPR) of the Peach Bottom Atomic Power Station. The staff conducted these reviews for all operating nuclear power plants to integrate performance information and to plan for inspection activities at your facility through March 2000. The focus of this performance review was to identify changes in performance over the past six months, and to allocate inspection resources accordingly.

We did not identify any areas in which your performance warranted additional new inspections beyond the core inspection program. During the next six months we plan to conduct our core inspection program and the initiative inspection of your corrective action program that was discussed in our PPR letter dated April 9, 1999. We also plan to continue our inspections of your independent spent fuel storage facility.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated review of licensee performance trends. The PIM includes items summarized from inspection reports or other docketed correspondence between the NRC and PECO Energy from September 1998 through July 1999. As noted above, greater emphasis was placed on those issues identified in the past six months during this performance review. The NRC does not attempt to document all aspects of licensee programs and performance that may be functioning appropriately. Rather, the NRC only documents issues that the NRC believes warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the Public Document Room as part of normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our plans for future inspection activities at your facility so that you will have an opportunity to prepare for these inspections and to provide us with feedback on any planned inspections which may conflict with your plant activities. Enclosure 2 details our inspection plan through March 2000 to coincide with the scheduled implementation of the revised reactor oversight process in April 2000. The rationale for each inspection outside the

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core inspection program is discussed above so that you are aware of the reason for emphasis in these program areas. Resident inspections are not listed due to their ongoing and continuous nature.

If circumstances arise which cause us to change this inspection plan, we will contact you to discuss the change as soon as possible. Please contact me at (610) 337-5233) with any questions you may have.

Sincerely,

Original Signed By:

Curtis J. Cowgill, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Docket Nos. 50-277, 50-278
License Nos. DPR 44, DPR-56

Enclosures: 1. Plant Issues Matrix
2. Inspection Plan

cc w/encl:
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J. Doering, Vice President, Peach Bottom Atomic Power Station
M. Warner, Plant Manager, Peach Bottom Atomic Power Station
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United States Nuclear Regulatory Commission

PLANT ISSUE MATRIX

By Primary Functional Area

Region I

PEACH BOTTOM

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/14/1999	1999301	Pri: OPS	NRC	NEG	Pri: 3A	**LIMITED SENIOR REACTOR OPERATOR INITIAL EXAMS**
		Sec:			Sec: 3B	A performance deficiency was identified during the performance of a JPM when an applicant, while operating the refueling bridge under the direction of a fuel handling director (FHD), allowed the mast to make contact with the south fuel prep machine handrail. The mast was in the normal up position with no fuel grappled. Although the contact was minor and no damage resulted, the event indicated a lack of oversight on the part of the FHD and inattentiveness on the part of the applicant.
					Ter:	
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
07/14/1999	1999301	Pri: OPS	NRC	POS	Pri: 3A	**LIMITED SENIOR REACTOR OPERATOR INITIAL EXAMS**
		Sec:			Sec:	Six Limited Senior Reactor Operator (LSRO) applicants were administered initial licensing exams. All applicants successfully passed all portions of the exam.
					Ter:	
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
06/28/1999	1999005	Pri: OPS	NRC	POS	Pri: 1B	**OPERATOR RESPONSE TO OFF-NORMAL CONDITIONS**
		Sec:			Sec: 3A	Operators took prompt and effective actions in response to three off-normal conditions during the period: 1) a loss of power to the Unit 3 primary feedwater control computer, 2) a Unit 2 plant monitoring system computer interruption, and 3) a Unit 3 reactor core isolation cooling system high suction pressure alarm. Appropriate follow-up actions were completed or planned by station personnel.
					Ter:	
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
06/28/1999	1999005	Pri: OPS	NRC	POS	Pri: 1C	**NUCLEAR QUALITY ASSURANCE ASSESSMENT OF PLANT OPERATION ACTIVITIES**
		Sec:			Sec: 5A	During March through April 1999, Nuclear Quality Assurance (NQA) performed a thorough assessment of Plant Operations Activities. The assessment was comprehensive and provided several insights into current operations performance. The most significant NQA assessment finding was the identification of an adverse trend in the effectiveness of corrective actions to preclude repetition of some deficiencies.
					Ter:	
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
06/28/1999	1999005-01	Pri: OPS	Self	NCV	Pri: 1C	**INADVERTENT LOSS OF THE 3 EMERGENCY AUXILIARY TRANSFORMER DURING 343 START-UP BUS RES**
		Sec:			Sec: 3A	On May 21, 1999, unplanned engineered safety feature actuations occurred on both units due to the de-energization of the Unit 3 emergency auxiliary transformer during restoration of the 343 startup bus to the normal offsite power supply. The investigation for this event was excellent and provided detailed insights into its causes. The root cause of this event was unclear management expectations for controlling equipment configuration status. The lack of adequate written instructions for equipment status control resulted in a Severity Level IV violation that was treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This item is documented in PECO's corrective action program as PEP I0009864.
					Ter: 5B	
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
05/17/1999	1999004	Pri: OPS	NRC	NEG	Pri: 1C	**OPERATIONS PERSONNEL RESPONSETO HIGH CONTROL ROD DRIVE (CRD) SEAL TEMPERATURES**
		Sec:			Sec: 1A	Inspectors identified two discrepancies during the review of a high temperature condition (above 500 F) on a Unit 3 control rod drive (CRD). The station had not incorporated into operating response procedures the practice of moving a CRD from the full out position to correct a high temperature condition. In addition, operators were not documenting in the CRD discrepancy log that a CRD was moved to reduce the temperature.
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Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						

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Region I
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
05/17/1999	1999004	Pri: OPS	NRC	POS	Pri: 1A	**EQUIPMENT OPERATOR (EO) PERFORMANCE DURING DAILY ROUNDS**
		Sec:			Sec: 3A	Equipment operators performed well during plant rounds. They properly completed surveillance readings and reported abnormal plant conditions. The use of peer mentors for improving performance of newly qualified equipment operators was a positive practice.
					Ter:	
Dockets Discussed:						
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
05/17/1999	1999004	Pri: OPS	NRC	POS	Pri: 1C	**SITE USE OF OVERTIME**
		Sec:			Sec:	PECO controlled the overtime hours of operations and maintenance personnel within the limits of the technical specifications and administrative procedures.
					Ter:	
Dockets Discussed:						
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
04/05/1999	1999002	Pri: OPS	Self	NEG	Pri: 1C	**REACTOR CORE ISOLATION COOLING (RCIC) ISOLATION DURING SYSTEM RESTORATION**
		Sec:			Sec: 1A	An unexpected engineered safety feature system isolation occurred during restoration of the Unit 3 reactor core isolation cooling (RCIC) system. As the reactor operator opened the RCIC outboard isolation valve during re-pressurization of the system, RCIC isolated due to a high steam flow condition. Non-specific procedural guidance regarding the opening methodology for the RCIC outboard isolation valve was a contributing cause.
					Ter:	
Dockets Discussed:						
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
04/05/1999	1999002	Pri: OPS	NRC	POS	Pri: 1B	**ANNUAL LICENSED OPERATOR REQUALIFICATION EXAMINATIONS**
		Sec:			Sec: 1C	The performance of two crews observed during the annual licensed operator examination was good in the areas of event recognition and diagnosis, control board manipulations, technical specification usage, and event classification. Improvements were noted, from the 1998 requalificaiton examination observations, in the conduct of crew briefs and the use of three part communications.
					Ter:	
Dockets Discussed:						
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
02/15/1999	1999001	Pri: OPS	NRC	NEG	Pri: 5A	**Corrective Action System Review**
		Sec:			Sec: 5C	Station corrective action processes were effective in identifying and resolving significant conditions adverse to quality. Problem identification was good for significant issues under the Performance Enhancement Program (PEP) process, but inconsistencies were noted in the identification and reporting of lower-level issues under lower tier reporting systems. Most investigations were thorough and completed in a timely manner. Problem solution was generally effective. However, inspectors noted a backlog of corrective action items awaiting reviews for adequacy. Station management stated that they had recognized some shortcomings in the corrective action processes and had begun improvement initiatives.
					Ter: 1C	
Dockets Discussed:						
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
02/15/1999	1999001	Pri: OPS	NRC	POS	Pri: 5A	**Nuclear Review Board Meeting**
		Sec:			Sec:	The Nuclear Review Board provided good independent discussion and evaluations of the topics presented during the February 4, 1999 meeting. The questions directed to the presenters by the members of the Board during this meeting were probing and insightful.
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Dockets Discussed:						
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						

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Region I

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
01/04/1999	1998011	Pri: OPS	NRC	NEG	Pri: 3A	COLD WEATHER PREPARATIONS PROCEDURAL NON-COMPLIANCE (CLOSED) VIOLATION (VIO) 50-277(278
		Sec:			Sec: 2B	Procedure adherence in the performance of winterizing procedures was improved. However, weaknesses in station winterizing procedures and personnel attentiveness to heating/ventilating system equipment contributed to some minor, cold weather-related equipment problems.
Dockets Discussed:					Ter:	
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
01/04/1999	1998011	Pri: OPS	NRC	POS	Pri: 3A	CONDUCT OF OPERATIONS
		Sec:			Sec: 1A	The plant operators performed well during the Unit 3 shutdown and startup for the instrument nitrogen leak repair and the reduction in power for replacement of the main turbine lubricating oil baffler valve and pump. Procedures were properly followed and communications and shift oversight were effective and professional.
Dockets Discussed:					Ter:	
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
01/04/1999	1998011	Pri: OPS	NRC	POS	Pri: 5C	INOPERABLE OFF-SITE POWER COURCE AND STATION BLACKOUT LINE DUE TO THE FAILURE OF THE 2 E
		Sec:			Sec: 1B	Control room operators responded as expected to an electrical transient caused by a loss of the 2 emergency auxiliary transformer. Licensee personnel took timely and effective corrective actions to repair damaged terminal components, address the generic concerns, and restore the emergency transformer to operation.
Dockets Discussed:					Ter: 5B	
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
01/04/1999	1998011-01	Pri: OPS	Self	NCV	Pri: 1C	LOSS OF OFF-SITE POWER SOURCE AND 2SU BUS TRIP DUE TO ELECTRICAL BUS SWITCHING DURING P
		Sec:			Sec: 1B	On November 30, 1998, inadequacies in a breaker manipulation procedure led to an unexpected loss of one off-site power source and several emergency safety feature actuations. Plant operators performed well during this event while challenged by the loss of control rod drive pumps and reactor water cleanup system isolation on both units and a recombiner isolation and power reduction on Unit 3. This non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation (NCV), consistent with Section VII.B.1 of the NRC Enforcement Policy.
Dockets Discussed:					Ter:	
05000277 PEACH BOTTOM 2						
01/04/1999	1998011-02	Pri: OPS	NRC	VIO IV	Pri: 1C	LICENSED OPERATOR REQUALIFICATION TRAINING PROGRAM
		Sec:			Sec:	Three licensed operators failed to successfully complete requalification training during the licensee requalification training program which ran from April 1994 through March 1996. Additionally, as a result of the failure to make up missed training until April 1998, one operator license renewal application (NRC Form 398), was submitted to the NRC with inaccurate information. The application incorrectly certified that the applicant had met the requirements of the approved requalification program during the effective term of the then current license. This was a violation of 10 CFR 55.57(a)(4) and 10 CFR 55.9. Corrective actions for the missed training and inaccurate NRC Form 398 were adequate.
Dockets Discussed:					Ter:	
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						
12/11/1998	1998010	Pri: OPS	Self	NEG	Pri: 3A	RESIDUAL HEAT REMOVAL SYSTEM CONFIGURATION CONTROL (UNIT 2)
		Sec:			Sec: 1A	An incomplete, one-time use procedure and a poor turnover between operators during system restoration caused four residual heat removal system vent valves to be left mispositioned. These mispositioned valves resulted in several hundred gallons of water from the 2B RHR subsystem spilling onto the Unit 2 torus room floor. This event was indicative of continued station challenges in the area of plant/system status control.
Dockets Discussed:					Ter:	
05000277 PEACH BOTTOM 2						
05000278 PEACH BOTTOM 3						

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12/11/1998	1998010	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter:	**CONDUCT OF OPERATION** Very good performance by operations personnel was observed during the Unit 2 outage (2R12). However, some inadequacies with logkeeping practices were noted during the inspection period. **Dockets Discussed:** 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3
12/11/1998	1998010	Pri: OPS Sec:	NRC	POS	Pri: 3A Sec: 5B Ter:	**OUTAGE SURVEILLANCE PERFORMANCE BY THE QUALITY ASSURANCE ORGANIZATION** Quality assurance personnel performed substantial oversight of various activities and provided very good insights into the performance of all work groups involved with the 2R12 outage. **Dockets Discussed:** 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3
10/28/1998	1998008	Pri: OPS Sec:	NRC	NEG	Pri: 1B Sec: 3B Ter:	**Operator Performance During Loss of Cooling To The 3C Main Transformer** On August 21, 1998, Unit 3 operators commenced a down power maneuver due to loss of cooling to the main transformer. The reduced load prevented a loss of the main transformer and plant transient when the deluge system activated. The initial response by the operators for the loss of cooling to the main transformer and subsequent deluge activation was good. Due to the power reduction, the flow in the recirculation system loops became mismatched in excess of the Technical Specification limit. This condition was identified and corrected within the time allowable by Technical Specifications. Failure of operations personnel to fully understand the effect of xenon on recirculation flow and closely monitor recirculation flow contributed to this involuntary entry into a Technical Specification Action and Limiting Condition for Operation. **Dockets Discussed:** 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3
10/28/1998	1998008	Pri: OPS Sec:	Self	NEG	Pri: 3C Sec: 5C Ter: 3B	**Inadvertent Shutdown of the 3C Drywell Chiller** On August 22, 1998, during performance of the Unit 3 turbine building rounds, an equipment operator inadvertently shutdown the 3C drywell chiller. Since the chiller was quickly restarted, the temperature and pressure increases in the drywell were small and posed a small safety risk to the plant. An engineering evaluation for a similar event that occurred on March 25, 1997, was not effective to preclude the August 22, 1998 event. **Dockets Discussed:** 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3
10/28/1998	1998008	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter:	**SUSTAINED CONTROL ROOM OBSERVATION** The operators in the control room demonstrated very good communication practices in their extensive use of three part communications. The operators also demonstrated very good questioning attitudes in their pursuit of the scope of a breaker problem and their review of procedures. Peer checking and self checking were usually employed effectively. One error was noted in which the improper unit's procedure was initially used to substitute computer variables for heat balance calculations but later corrected. Logs generally were kept accurately, but an erroneous plant status entry went undetected through a shift turnover, indicating a cursory review of that entry. **Dockets Discussed:** 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3
10/28/1998	1998008	Pri: OPS Sec:	NRC	STR	Pri: 1C Sec: 3A Ter:	**Limited Senior Reactor Operator (LSRO) Requalification Program** The Senior Reactor Operator Limited to Fuel Handling (LSRO) program was good overall. The LSRO program guidelines and examinations were comprehensive and well maintained by the program coordinator and LSRO license maintenance was well documented. The areas of exam security, remediation, operator feedback, and medical records were acceptable. **Dockets Discussed:** 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3

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10/28/1998	1998008-01	Pri: OPS Sec:	Self	VIO IV	Pri: 3 Sec: 3A Ter: 5C	**RWCU SYSTEM STARTUP PROCEDURE** Two Unit 3 reactor water cleanup (RWCU) system events occurred during this inspection due to poor system configuration control. These events resulted in an entry into emergency operating procedures due to a steam leak on the non-regenerative heat exchanger and an automatic engineered safety feature (ESF) isolation. The causes were less than adequate turnovers between senior reactor operators and non-licensed operators, incomplete post-maintenance testing instructions, and an inadequate RWCU startup procedure. Station personnel failed to properly maintain the RWCU startup procedure, resulting in a violation of Technical Specification 5.4.1, Procedures. Although station personnel had previously developed some initiatives to reduce plant configuration control problems, they had not made sufficient progress implementing them to preclude these events. **Dockets Discussed:** 05000277 PEACH BOTTOM 2
10/28/1998	1998008-02	Pri: OPS Sec:	Licensee	NCV	Pri: 3A Sec: 1A Ter: 3B	**Torus/Drywell Vacuum Breaker Loss of Seated Indication (Unit 2)** Operators did not verify that a torus-to-drywell vacuum breaker was closed within 10 hours of the discovery of an unreliable indication, as required by technical specifications. This event was caused by the failure to adhere to equipment operator rounds and log review practices by operations personnel. This non-repetitive, licensee-identified, and corrected violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. **Dockets Discussed:** 05000277 PEACH BOTTOM 2
09/22/1998	1998301	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: 3B Ter:	**Reactor Operator and Senior Reactor Operator Initial Exams** Two senior reactor operator upgrade, six instant and four reactor operator applicants were administered initial licensing exams. All applicants passed the examination, were well prepared, and received licenses. The initial submittal of the written examination was identified by NRC staff to be unacceptable. The examination contained multiple examples of questions that were inadequate for several reasons as noted herein. PECO staff subsequently revised the written examination in a timely manner. The facility provided six post examination comments that were resolved but were of a technical nature indicating that a more detailed review of the reference material used in the construction of the examination was needed. **Dockets Discussed:** 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3
09/21/1998	1998008	Pri: OPS Sec:	Licensee	WK	Pri: 1A Sec: 3A Ter: 5A	**Reactor Water Cleanup System Configuration Control Events (Unit 3) and (Closed) LER 50-278/3-98-004** Two Unit 3 reactor water cleanup (RWCU) system events occurred during this inspection due to poor system configuration control. These events resulted in an entry into emergency operating procedures due to a steam leak on the non-regenerative heat exchanger and an automatic engineered safety feature (ESF) isolation. The causes were less than adequate turnovers between senior reactor operators and non-licensed operators, incomplete post-maintenance testing instruction, and an inadequate RWCU startup procedure. Station personnel failed to properly maintain the RWCU startup procedure, resulting in a violation of Technical Specification 5.4.1, "Procedures." Although station personnel had previously developed some initiatives to reduce plant configuration control problems, they had not made sufficient progress implementing them to preclude these events. **Dockets Discussed:** 05C00277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3
06/28/1999	1999005	Pri: MAINT Sec:	NRC	NEG	Pri: 1C Sec: Ter:	**SAFE SHUTDOWN EMERGENCY LIGHTING REVIEW** Required station emergency lighting units were tested and inspected according to plant procedures and consistent with Appendix R requirements. Corrective maintenance was performed promptly. Maintenance action requests were not being reviewed for maintenance rule implication due to an action request database error that indicated the lighting units were not within the scope of the rule. This deficiency was entered into the corrective action program and corrected. **Dockets Discussed:** 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3

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PLANT ISSUE MATRIX
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Region I

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
06/28/1999	1999005	Pri: MAINT Sec:	Licensee	NEG	Pri: 3A Sec: 3B Ter:	**EQUIPMENT STATUS CONTROL ISSUE ASSOCIATED WITH INSTRUMENTATION & CONTROLS WORK** During post maintenance testing, Instrumentation and Controls (I&C) technicians identified that they had not properly restored a core spray system flow transmitter to service following maintenance. Overall the PECO i stigation and corrective actions for this event were appropriate and identified that incorrect assumptions were made regarding restoration instructions and some actions stated in the clearance and tagging manual were not performed.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
05/17/1999	1999004	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	**THERMOLAG REMEDIATION WORK** Maintenance activities associated with Thermolag and penetration seal upgrades were typically well-controlled.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
05/06/1999	1999002-01	Pri: MAINT Sec:	Licensee	NCV	Pri: 2A Sec: Ter:	**INOPERABILITY OF BOTH CHANNELS OF THE UNIT 2 ROD BLOCK MONITOR DUE TO A LOCAL POWER RA** A wiring error dating back to original construction was discovered which resulted in non-conservative inputs to both channels of the Unit 2 rod block monitor for 29 of 185 control rods. A thorough root-cause analysis was performed for this event and corrective actions were comprehensive. In accordance with the NRC Enforcement Policy, Section VII.B.3, Violations Involving Old Design Issues, the NRC is exercising enforcement discretion and not citing this violation. (NCV 50-277/99-02-01)
Dockets Discussed: 05000277 PEACH BOTTOM 2						
04/05/1999	1999002	Pri: MAINT Sec:	Licensee	NEG	Pri: 3B Sec: 2A Ter:	**E-3 EMERGENCY DIESEL GENERATOR (EDG) SCHEDULED MAINTENANCE OUTAGE** Although the E-3 emergency diesel generator 24 month overhaul maintenance outage was generally well planned, unexpected coolant water jacket leaks and a speed relay failure significantly extended the emergency diesel generator outage length. In anticipation of exceeding the technical specification (TS) limiting condition for operation (LCO) for the length of time an emergency diesel generator can be out of service, PECO staff requested the NRC to grant enforcement discretion and extend the out of service time by three days. Since PECO staff returned the emergency diesel generator to service within the TS LCO time, the NRC did not need to grant the enforcement discretion.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
02/15/1999	1999001	Pri: MAINT Sec:	NRC	NEG	Pri: 2A Sec: 3A Ter:	**Unit 3 HPCI Scheduled Maintenance Outage** The Unit 3 High Pressure Coolant Injection (HPCI) on-line outage work was well planned with an effective post-maintenance test. Although the station returned the HPCI system to an operable status within technical specification requirements, problems with the gland seal condensate pump resulted in the HPCI outage being extended past the original schedule.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
02/15/1999	1999001	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 1C Ter:	**Use of PRA Techniques During Plant Work Activities** The station has effectively incorporated the probabilistic risk assessment individual plant evaluations for core damage frequency and large early release frequency into the planning of system outages and assessment of plant risk due to emergent work.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						

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PLANT ISSUE MATRIX
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Region I
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
01/04/1999	1998011-03	Pri: MAINT Sec:	NRC	NCV	Pri: 3A Sec: 4B Ter: 5A	**FAILURE TO MEET TECHNICAL SPECIFICATION (TS) SURVEILLANCE REQUIREMENTS FOR THE ABSOLUTE** Station personnel discovered that a Technical Specification Surveillance Requirement for average power range monitor channel calibration was not met during Unit 2 power ascension due to an inaccurate heat balance calculation. The heat balance calculation inaccuracy was due to substitute values installed by instrument and control and engineering personnel during flow transmitter calibrations. The calculated heat balance values were always conservative from a safety perspective and station personnel took adequate and reasonable corrective actions for this event. This non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation (NCV), consistent with Section VII.B.1 of the NRC Enforcement Policy.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
12/11/1998	1998010	Pri: MAINT Sec:	Self	NEG	Pri: 1C Sec: 3B Ter:	**E-22/E-42 LOSS OF COOLANT/LOSS OF OFF-SITE POWER FUNCTIONAL TESTS** Operations staff were unnecessarily challenged during the performance of the E-22 and E-42 Loss of Offsite power/Loss of Coolant Accident functional tests, due to surveillance test procedure weaknesses. This issue was similar to others documented in NRC Inspection Report 50-277(278)/98-07, where inadequate procedures resulted in unexpected plant equipment responses.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
12/11/1998	1998010	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: 2B Ter:	**SCRAM AIR HEADER REPLACEMENT MODIFICATION (UNIT 2)** Contractor personnel performing modification work on the Unit 2 scram air header exhibited poor foreign material control practices, contrary to specific work order instructions. Weaknesses in contractor oversight were identified by these poor practices. In addition, PECO personnel did not enter the poor foreign material control practices into any of the station corrective action processes even though this issue appeared to meet the criteria for entry into the Performance Enhancement Program (PEP).
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
12/11/1998	1998010	Pri: MAINT Sec:	Self	NEG	Pri: 3A Sec: 2B Ter:	**UNIT 3 E-33 BUS TRIP DUE TO INADVERTENT OPERATION DURING A UNIT 2 SURVEILLANCE PROCEDURE** On October 25, 1998, the Unit 3 E33 bus was inadvertently tripped during the performance of a surveillance procedure that functionally trip tested the E32 and E324 bus overcurrent relays. This resulted in an 'A' channel half scram, a full reactor water clean up isolation, loss of the 'C' standby gas treatment fan, an inboard primary containment isolation system group 3 isolation and subsequent loss of reactor building ventilation, and a half primary containment isolation system group 1 isolation that did not cause any valve motion. Control room personnel entered T-103, Revision 11, "Secondary Containment Control" due to high main steam line tunnel temperatures caused by the trip of the reactor building ventilation. Procedure, T-103, was exited after the reactor building ventilation was restarted and the mainsteam line tunnel temperatures returned to normal. Since this event caused several automatic engineered safety feature (ESF) actuations, operations supervision made a four hour notification to the NRC per 10 CFR 50.72. No violations of NRC requirements occurred due to this event. However, inadequate self-checking and peer checking by the instrument and control technicians performing the surveillance procedure were determined to be the root cause of this event.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
12/11/1998	1998010	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 2B Ter:	**UNIT 2 EMERGENCY CORE COOLING SYSTEM (ECCS) SUCTION STRAINER MODIFICATION P-350** PECO completed the emergency core cooling system suction strainer replacement modification, from NRC Bulletin 96-03 commitments, during the 2R12 outage. The PME and work control activities were greatly improved from the modification performed during the previous Unit 3 outage and were effective in ensuring that no foreign material was left in the ECCS systems. The modified systems were verified operable during post-maintenance testing.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						

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12/11/1998	1998010-01	Pri: MAINT Sec:	Licensee	VIO IV	Pri: 3A Sec: 5A Ter:	**INCORRECT REFUEL FLOOR VENT EXHAUST RADIATION DETECTOR DISCONNECTED DURING CALIBRATI** On August 10, 1998, chemistry technicians were performing ST-C-095-878-2, "Refuel Floor Vent Exhaust Rad Monitor Calibration and Functional Test for RIS-2-17-458A and C." During calibration of the C detector, the technicians inadvertently removed and dropped the D detector. The technicians performing this work did not stop and notify the control room operations personnel or Chemistry Supervision that they had removed the D detector and dropped it even though they were directed by ST-C-095-878-2 to report any unexpected conditions. The behavior of the technicians to not tell details about the event for several days, and only when asked, was not acceptable. The licensee corrective actions were narrowly focused on the chemistry department and did not include the other departments at the station. Procedural non-adherence has been an issue at the station for the past year. This was considered a violation of the station Technical Specifications for not properly implementing procedures.
Dockets Discussed: 05000277 PEACH BOTTOM 2						
12/11/1998	1998010-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 3A Sec: 2B Ter:	**REFUELING PLATFORM ACTIVITIES** Generally, core alterations during the 2R12 outage were conducted in a orderly and professional manner using precise communications and thorough shift turnover. However, three fuel movement errors occurred during the refueling activities on October 12 and 22, 1998. These errors were caused by a failure to properly verify component location and orientation as required by procedure. The Refueling Platform Operator failed to perform an adequate self-check and the Spotter failed perform an adequate peer-check during these fuel bundle moves. These errors resulted in a violation of Technical Specification 5.4.1, "Procedures." This non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.
Dockets Discussed: 05000277 PEACH BOTTOM 2						
10/28/1998	1998008	Pri: MAINT Sec:	Self	NEG	Pri: 3B Sec: 2B Ter:	**Fire Main Leak** Weaknesses in maintenance planning and work practices led to a significant water leak on the station fire main on August 23, 1998. Water from the leak entered the safety related emergency service water/high pressure service water pump house via underground electrical conduits and degraded penetration seals. The engineering evaluation, that the penetration seal leakage was within design assumptions for a design basis flooding event, and pump operability was not affected, was adequate.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
06/28/1999	1999005-02	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: 5A Ter:	**FIRE PROTECTION PLAN NON-CONFORMANCES (UNITS 2 AND 3)** During the past nine months, PECO engineering personnel have identified several subtle, historical non-conformances to the Peach Bottom Fire Protection Plan during their reviews of the fire protection program. These reviews have been notably comprehensive with appropriate corrective actions taken for deficiencies identified. The non-conformances with the Fire Protection Plan constituted a Severity Level IV violation that was treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. These non-conformances are documented in PECO's corrective action program as PEPs I0009023, I0009584, and I0009737. (EA 99-192)
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
05/06/1999	1999002	Pri: ENG Sec:	Licensee	NEG	Pri: 4B Sec: 3A Ter:	**LOCKUP OF UNIT 2 PLANT MONITORING SYSTEM COMPUTERS DURING COMPUTER TESTING** Unit 2 plant monitoring system computers locked-up during testing, because an information systems engineer did not adhere to station policy regarding stopping of testing when unexpected conditions occur. The station's root cause analysis and planned corrective actions were comprehensive. This event did not constitute a violation of NRC requirements.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						

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04/05/1999	1999002	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: 3A Ter:	**GENERAL COMMENTS** The inspectors noted several cases where errors by engineering department personnel resulted in challenges to plant systems or components related to motor operated valve calculations, investigation of the 3 B core spray breaker failure, computer testing and a Unit 2 electro-hydraulic control system modification.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
02/15/1999	1999001	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: 5A Ter:	**Motor-Operated Valve Problem** In five instances, nonconformance report dispositions for motor-operated valve (MOV) anomalies were narrowly focused. Although operability determinations for the valves were acceptable, the causes of the anomalus conditions, such as lubrication degradation, were not adressed or evaluated for corrective action. PECO was implementing corrective actions to address MOV program deficiencies.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
02/15/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 5C Ter:	**Limitorque Technical Update 98-01 for AC Motor-Operated Valves** PECO performed a comprehensive assessment of new information regarding motor-operated valve (MOV) output capability contained in Limitorque Technical Update 98-01. Operability determinations used best available industry data for calculating motor actuator performance capabilities and used reasonable technical assumptions. Planned long-term corrective actions appropriately addressed restoration of MOV design margins.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
02/15/1999	1999001-01	Pri: ENG Sec:	NRC	NCV	Pri: 4B Sec: 5A Ter:	**HPCI System Gland Seal Condenser Leak (Unit 2)** A significant leak on the Unit 2 High Pressure Coolant Injection (HPCI) system gland seal condenser was caused by an inadequate maintenance procedure. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as PEP I0009358. Engineering troubleshooting and investigation efforts following the significant leak on the Unit 2 high pressure coolant injection system gland seal condenser resulted in effective corrective actions. However, operations and engineering had missed opportunities, prior to the leak, to identify the cause of the abnormal high pressure coolant injection system reponse.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
01/04/1999	1998011	Pri: ENG Sec:	Licensee	NEG	Pri: 4C Sec: 4A Ter:	**PERFORMANCE DURING CHALLENGES TO THERMAL LIMIT MARGINS AND APRM TECHNICAL SPECIFICAT** Three reactor core thermal management problems occurred during this inspection period related to the 3D MONICORE program. Two problems were related to configuration management of input data to the program and one was related to unexpected program results. The licensee investigated these problems and took appropriate initial actions and developed appropriate corrective actions. No thermal limits were exceeded as a result of these problems.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
12/11/1998	1998010	Pri: ENG Sec:	NRC	NEG	Pri: 2A Sec: 4C Ter: 4B	**MOTOR OPERATED VALVE FAILURES DURING THE UNIT 2 REFUELING OUTAGE** Four examples of failures or degraded conditions on safety related motor operated valves were identified during the 2R12 outage. The operability determinations for each valve were adequate and the valves were capable of performing their safety function when required. Although, the program and technical requirements for these valves were fulfilled, the failures and degraded conditions found during the outage indicated a negative trend in motor operated valve reliability.
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12/04/1998	1998009	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: 4C Ter:	**4 KV ELECTRICAL DISTRIBUTION SYSTEM** The team concluded that the installed 4 Kv electrical distribution system was consistent with the design basis, and that this system was capable of performing its design function during normal and abnormal operating conditions. Also, the existing procedures for operation, surveillance, and maintenance of system components were accurate and consistent with the licensing and design bases.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
12/04/1998	1998009	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 4A Ter:	**IMPLEMENTATION OF 10 CFR 50.50 PROGRAM** PECO has implemented an acceptable 10 CFR 50.59 program that produced applicability determinations and safety evaluations of good quality, met regulations and applicable plant procedures, and provided sufficient details and references to support the conclusions drawn.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
12/04/1998	1998009-01	Pri: ENG Sec:	NRC	VIO IV	Pri: 4A Sec: 4B Ter:	**REACTOR CORE ISOLATION COOLING (RCIC) SYSTEM** The RCIC system was maintained operable and capable of performing its safety function. The existing procedures for operation, surveillance, and maintenance of system components were generally accurate and consistent with the licensing and design bases. However, weaknesses were found in dispositioning repetitive failures of primary containment isolation valve CHK-3-13C-38 without thorough documented engineering investigation. The failures remain a troubleshooting priority for the system manager. Two discrepancies were identified involving the design basis stroke times for the torus suction valves in procedure ST-0-013-301-2 and the design basis torus water temperature in procedure EOP T-102, which represented a violation of 10 CFR 50, Appendix B, Criterion III, Design Control. PECO took appropriate actions to address the violation and also had ongoing actions, such as the calculation enhancement program, to address the problem.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
10/28/1998	1998008-03	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: 5A Ter: 5C	**Potential for Bypass of Pressure Suppression Pool** Engineering personnel took prompt and effective corrective actions following their identification of the potential to bypass the pressure suppression function of the torus during simultaneous purging of the torus and drywell as a result of postulated failures. In accordance with the NRC Enforcement Policy, Section VII.B.3, Violations involving Old Design Issues, the NRC is exercising enforcement discretion and not citing this violation.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
06/28/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	**RADIOACTIVE WASTE SOURCES AND PROCESSING SYSTEMS, RADIONUCLIDE SCALING FACTORS, WAST** PECO implemented effective programs in the areas of radioactive waste source evaluation, processing and handling, determination of radionuclide scaling factors, waste classification, and volume reduction efforts. PECO developed appropriate scaling factors for hard to detect radionuclides, performed appropriate radionuclide concentration averaging, and implemented waste volume reductions efforts.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						
06/28/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: Ter:	**PERSONNEL DIVING IN UNIT 2 SPENT FUEL POOL** PECO thoroughly planned for the personnel diving in the Unit 2 spent fuel pool. The diving evolutions were carefully monitored by health physics personnel. PECO's excellent dose reduction efforts resulted in significantly lower than expected overall dose to the divers.
Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3						

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06/28/1999	1999005	Pri: PLTSUP Sec: Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3	NRC	POS	Pri: 3A Sec: 1C Ter:	**RADIOACTIVE MATERIAL TRANSPORTATION ACTIVITIES** PECO implemented an effective radioactive waste and radioactive material packaging and shipping program and successfully shipped irradiated hardware and clean-up filters from its Unit 3 spent fuel storage pool.
05/17/1999	1999004	Pri: PLTSUP Sec: Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3	NRC	POS	Pri: 1C Sec: 2A Ter:	**READINESS OF SITE EMERGENCY RESPONSE FACILITIES** Communications equipment, supplies and data acquisition systems were maintained in a high state of operational readiness in the Technical Support Center and the Operational Support Center. Emergency siren activation equipment was fully operational. Equipment and supplies for off-site dose assessment teams were properly calibrated and fully functional.
05/17/1999	1999004-01	Pri: PLTSUP Sec: Dockets Discussed: 05000278 PEACH BOTTOM 3	Licensee	NCV	Pri: 3A Sec: 1C Ter:	**INADVERTENT DISABLING OF A UNIT 3 SAFEGUARD SYSTEM VITAL AREA DOOR** On April 6, 1999, site security personnel discovered that a Unit 3 vital area door alarm had been disabled. The alarm had inadvertently been disabled by security personnel during planned maintenance on security system equipment. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This item is in PECO's corrective action program as PEP I0009658.
04/05/1999	1999002	Pri: PLTSUP Sec: Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3	NRC	POS	Pri: 3A Sec: 2B Ter:	**RADIOLOGICAL CONTROLS-RADIOACTIVE MATERIALS, CONTAMINATION, SURVEYS, AND MONITORING** The staff effectively controlled activities in radiological controlled areas. Health Physics technicians performed proper surveys and properly documented survey results. Radiological housekeeping conditions were noted to be good. The number and type of personnel contaminations were tracked, trended, and evaluated for cause and corrective actions. The radiological surveys, monitoring, and controls were implemented with properly calibrated devices.
04/05/1999	1999002	Pri: PLTSUP Sec: Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3	NRC	STR	Pri: 2B Sec: Ter:	**RADIOLOGICAL CONTROLS-AS LOW AS REASONABLY ACHIEVABLE (ALARA)** PECO implemented an effective program to maintain occupational radiation exposure as low as is reasonably achievable (ALARA), and the ALARA efforts and results for 1998 were good, including the management of radiologically significant outage work.
04/05/1999	1999002	Pri: PLTSUP Sec: Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3	NRC	STR	Pri: 5A Sec: 5C Ter: 5B	**QUALITY ASSURANCE IN RP&C ACTIVITIES** PECO's self-identification and corrective action processes in the area of radiation protection were effective. Nuclear Quality Assurance surveillance reports, self-assessments, and the corrective action program continued to be effective in identifying, at a low threshold, deficiencies and improvement opportunities. Effective corrective actions were implemented when discrepancies were identified.

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02/15/1999	1999001	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 3A Sec: 3C	**Removal of Contaminated Filters from the Unit 3 Spent Fuel Pool** Generally, movement of the contaminated filters from the spent fuel pool to the shipping cask was performed well with good radiation technician monitoring and oversight and good ALARA awareness and actions by the workers. The inspector observed a slow response to an area radiation monitor alarm.
		Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3				
02/15/1999	1999001	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 2B Sec:	**Status of Security Facilities and Equipment** Security facilities and equipment were determined to be well maintained and reliable. Security procedures were being properly implemented. Security staff knowledge, performance and training were determined to be acceptable. Security organization and administration were adequate to ensure effective implementation of the program.
		Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3				
01/04/1999	1998011	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 3A Sec: 3C	**RADIATION PROTECTION CONTROLS DURING HIGH RADIATION WORK ACTIVITIES** Radiation protection personnel provided very good oversight of control rod blade component removal from the Unit 3 spent fuel pool and replacement of a Unit 2 traversing incore probe. Good awareness for As-Low-As-Reasonably-Achievable (ALARA) by personnel involved with this work, and effective planning and monitoring by radiation protection personnel resulted in low doses for these activities.
		Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3				
12/11/1998	1998010	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: 5A	**QUALITY ASSURANCE IN RADIOLOGICAL PROTECTION AND CHEMISTRY ACTIVITIES** There was active oversight of the radiological controls program and its implementation. PECO quality assurance personnel performed ongoing performance-based surveillances of radiological controls activities. PECO radiological controls supervisors and managers provided oversight of program implementation and effectiveness.
		Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3				
12/11/1998	1998010	Pri: PLTSUP Sec: Ter:	NRC	STR	Pri: 1C Sec: 3A	**UNIT 2 REFUELING OUTAGE RADIOLOGICAL CONTROLS** PECO established and implemented overall effective applied radiological controls and procedures for Unit 2 outage work activities. There were no significant unplanned external or internal exposures identified. Overall contamination controls were effective. Airborne radioactivity was minimized through use of decontamination and application of engineering controls. There was active oversight of implementation of controls by supervisors and managers.
		Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3				
12/11/1998	1998010	Pri: PLTSUP Sec: Ter:	NRC	STR	Pri: 1C Sec: 3A	**ALARA PROGRAM AND UNIT 2 REFUELING OUTAGE** PECO implemented an overall effective ALARA program. ALARA measures were incorporated into work processes. Numerous exposure reduction initiatives were implemented including decontamination, shielding, remote monitoring, use of mock-ups, and work monitoring via closed-circuit television.
		Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3				

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10/28/1998	1998008	Pri: PLTSUP Sec: Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3	NRC	STR	Pri: 3A Sec: 3B Ter:	**Radioactive Waste Processing, Handling, Storage, and Shipping** PECO implemented an effective radioactive waste processing, handling, storage, and radioactive material transportation program. Wastes were properly classified and packaged.
10/28/1998	1998008-04	Pri: PLTSUP Sec: Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3	NRC	VIO IV	Pri: 3A Sec: 5A Ter:	**Failure to Adhere to Radiation Protection Procedures for Source Checking Instruments** PECO provided generally good radiological controls oversight of incoming fuel shipments. However, a violation of radiation protection procedures associated with source checking of an alpha contamination counting instrument was identified by the NRC and was promptly corrected by PECO.
11/19/1998	1998012-01	Pri: OTHER Sec: Dockets Discussed: 05000277 PEACH BOTTOM 2 05000278 PEACH BOTTOM 3	NRC	IFI	Pri: 2A Sec: Ter:	**PAGER INCONSISTENCIES** The newly designed electronic notification pager system did not activate automatically as expected. Emergency responders were notified within 20 minutes after the Alert declaration after the pagers were manually activated. This did not negatively impact the outcome of the exercise with regards to meeting the facility timeliness requirements because it was a daytime exercise and most responders were in position within 10 minutes of the plant announcement.

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Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

ENCLOSURE 2

09/28/1999 14:39:53

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Inspection / Activity Plan

10/01/1999 - 03/31/2000

Units	Inspection Activity	Title	Number of NRC Inspectors / Individuals	Planned Dates Start	Planned Dates End	Inspection Type
2, 3	IP 73753	Inservice Inspection	1	10/11/1999	10/15/1999	Core
3	IP 83750	Occupational Radiation Exposure	1	10/18/1999	10/22/1999	Core
2, 3	IP 81700	Physical Security Program For Power Reactors	1	10/25/1999	10/29/1999	Core
2, 3	IP 60852	Isfsi Component Fabrication By Outside Fabricators	1	12/06/1999	12/10/1999	Regional Initiative
2, 3	IP 40500	Effectiveness Of Licensee Process to Identify, Resolve, And Prevent Problems	2	12/13/1999	12/17/1999	Regional Initiative
2, 3	IP 60854	Preoperational Testing Of An ISFSI	3	01/25/2000	01/26/2000	Regional Initiative
2, 3	IP 60854	Preoperational Testing Of An ISFSI	3	02/22/2000	03/10/2000	Regional Initiative
2, 3	IP 71001	Licensed Operator Requalification Program Evaluation	2	03/20/2000	03/24/2000	Core

This report does not include INPO and OUTAGE activities.
This report shows only on-site and announced inspection procedures.