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PSEG
Nuclear L.L.C.

March 7, 2007
LR-N07-0044

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Salem Nuclear Generating Station Units 1 and 2
Facility Operating License Nos. DPR-50 and 75
NRC Docket Nos. 50-272 and 50-311

Subject: Reply to Notice of Violation EA-06-205

On January 25, 2007, the NRC issued a Notice of Violation (NOV) to PSEG Nuclear (PSEG) concerning events surrounding a service water accumulator overpressure condition on July 3, 2003. The reply due date of this NOV was extended to March 7, 2007 per conversation between Mr. Steve Mannon of my staff and Mr. Arthur Burritt, Chief Reactor Projects Branch 3 Division of Reactor Projects. Attachment 1 to this letter contains the violation as cited in the EA-06-205 and Attachment 2 provides PSEG's response to that NOV.

Should you have any questions concerning this submittal, please contact J. Keenan at 856-339-5429.

Sincerely,

Attachments (2)

IE01

Mr. Samuel Collins, Administrator - Region I
U. S. Nuclear Regulatory Commission
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Attachment 1
LR-N07-0044

I. VIOLATION

10 CFR 50.9(a) requires, in part, that information required by license conditions to be maintained by the licensee shall be complete and accurate in all material respects.

10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," requires, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. Public Service Enterprise Group (PSEG) Procedure NC.WM-AP.ZZ-0000(Q), "Notification Process," Revision 6, dated June 24, 2003, Section 3.1, required PSEG personnel to identify and document a condition adverse to quality in the corrective action program by using a notification. Section 7.2 of this procedure defined a condition adverse to quality, in part, as a condition that has the potential to affect a safety-related function of systems, structures, or components.

Contrary to the above, on July 3, 2003, PSEG personnel did not promptly identify a condition adverse to quality that had the potential to affect a safety-related function of the service water system when a system valve alignment error led to the 12 service water accumulator pressure exceeding limits specified in Technical Specification 3.6.1.1. Specifically, a gas charging valve was inadvertently left open (misaligned) after a work task causing the accumulator pressure to exceed the technical specification limits for the system. The failure to identify the condition adverse to quality was (1) a result of the nuclear equipment operators, who identified the valve misalignment, providing incomplete and inaccurate information to control room personnel regarding the accumulator maximum pressure and the cause of the valve misalignment and (2) a failure by the control room supervisor to recognize the condition adverse to quality based on personal knowledge of the work task and the information provided by the equipment operators, even though some incomplete or inaccurate information was described. Neither the equipment operators nor the control room supervisor ensured that this condition adverse to quality was promptly identified and corrected by documenting the condition using a notification report.

This is a Severity Level IV violation (Supplement 1).

Attachment 2
LR-N07-0044

II. PSEG REPLY TO THE VIOLATION

1. Admission or Denial of the Alleged Violation:

   PSEG admits the alleged violation.

2. Reason(s) For The Alleged Violation:

   PSEG performed an extensive and comprehensive investigation immediately upon learning of the event. PSEG determined that less than adequate human performance standards by the employees, including inadequate personal responsibility, accountability, and integrity directly resulted in the violation. Since the time of the event in 2003, PSEG has undertaken significant efforts to improve site human performance, including putting in place the proven Fundamentals Tool Kit that has been successfully implemented at other Exelon sites. These efforts have improved individual performance at the station.

   PSEG would like to make one clarification regarding notifying the NRC of the accumulator overcharging event. The NRC noted in the NOV that PSEG "did not inform the NRC of the occurrence when it was finally identified." Once PSEG became aware of the event, an extensive investigation was initiated. PSEG's investigation was actively proceeding when identified by the NRC, and relevant information was unavailable because interviews of key witnesses were significantly delayed due to witness unavailability and coordination with witness counsel. Once PSEG efforts were completed, the company fully and completely cooperated with the NRC Office of Investigation, including supplying all requested reports and files associated with this matter.

3. Corrective Steps That Have Been Taken and the Results Achieved:

   PSEG promptly initiated a comprehensive investigation immediately upon learning of the July 3, 2003 service water accumulator incident. At the conclusion of that investigation, PSEG took significant remedial action, commensurate with the circumstances to prevent recurrence.

   Numerous improvements in the Corrective Action Program (CAP) have taken place since this event occurred in 2003. Though the overpressurization issue was not entered into the CAP at the time, reviews performed since this event have confirmed that station personnel have appropriate knowledge of the CAP and enter identified problems into the program at a low threshold.

4. Corrective Steps To Avoid Further Violations:

   No additional steps required.

5. Date When Full Compliance Will Be Achieved:

   PSEG is in full compliance