

Peach Bottom 3

Initiating Events



Significance: Aug 19, 2000

Identified By: Self Disclosing

Item Type: FIN Finding

EVENT FOLLOW-UP-UNIT 3 AUTOMATIC REACTOR SHUTDOWN

On August 7, Unit 3 automatically shutdown from 100% power when a one inch instrumentation rack root valve packing gland follower failed and caused a false reactor low level signal input into the reactor protection system. This failure occurred when the packing gland follower broke into two pieces allowing leakage of contaminated reactor coolant system water from the instrumentation piping. This leak was immediately isolated by actuation of the excess flow check valve in the instrumentation piping line. Unit 3 also experienced closure of Groups II and III primary containment isolation valves due to the false reactor low level signal. This event was of very low safety significance since the excess flow check valve functioned as designed and stopped the leak and all mitigating systems functioned as designed.

Inspection Report# : [2000008\(pdf\)](#)

Mitigating Systems

Significance: N/A Jun 08, 2000

Identified By: NRC

Item Type: AV Apparent Violation

POST-FIRE SAFE SHUTDOWN CIRCUIT ANALYSES

PECO adopted a licensing position that mechanical damage to alternative shutdown equipment resulting from fire-induced cable faults, as described in Information Notice 92-18, was outside the scope of the licensing and design bases of the facility. As a result, PECO did not evaluate the control circuits of the alternative shutdown equipment to determine if it was susceptible to this problem. Since a detailed review of the alternative shutdown capability at PBAPS was not performed as part of the scope of this inspection, the risk associated with this issue was not established. This issue is being treated as an apparent violation of Condition 2.C.4 of the operating licenses for both Unit 2 and Unit 3, which requires PECO to implement and maintain the fire protection program described in the NRC Safety Evaluation Reports. PECO has entered this issue into their corrective action program and has implemented reasonable compensatory measures pending final resolution of the issue. However, the issue of mechanical damage to safe shutdown equipment due to fire-induced cable faults is in contention between the NRC and the nuclear industry. As such, any further enforcement action will be deferred pending final resolution of this issue by the Nuclear Energy Institute and the NRC staff, in accordance with Enforcement Guidance Memorandum 98-02, Revision 2, issued February 2, 2000.

Inspection Report# : [2000003\(pdf\)](#)



Significance: Jun 08, 2000

Identified By: NRC

Item Type: AV Apparent Violation

POST-FIRE SAFE SHUTDOWN CIRCUIT ANALYSES

PECO's specification for performing circuit analyses of post-fire safe shutdown equipment stipulates that only one spurious actuation for each system affected by any one fire be analyzed. For the areas inspected, the team determined that PECO adequately protected against fire-induced spurious actuations. The team did not identify any additional spurious actuations which would have prevented achieving safe shutdown conditions in the post-fire operating environment. The assumption that only a single spurious actuation need be considered for any one system for any one fire is an apparent violation of the requirements of Section III.G. and III.L. of Appendix R to 10 CFR 50. PECO entered this issue into their corrective action program and have implemented reasonable compensatory measures. However, the issue of multiple spurious actuations of equipment in a post-fire environment is in contention between the NRC and the nuclear industry. As such, any further enforcement action will be deferred pending final resolution of this issue by the Nuclear Energy Institute and the NRC staff, in accordance with Enforcement Guidance Memorandum 98-02, Revision 2, issued February 2, 2000.

Inspection Report# : [2000003\(pdf\)](#)



Significance: Dec 29, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

E-2 EMERGENCY DIESEL GENERATOR RENDERED INOPERABLE BY A MISPOSITIONED JACKET COOLANT EXPANSION TANK BLOCK

VALVE

The inspectors identified a Non-Cited violation of very low safety significance (Green) of Technical Specification 5.4.1, because the gravity feed block valve in the line from the diesel generator coolant expansion tank was closed, contrary to system operating procedures. The closed block valve caused the E-2 emergency diesel generator (EDG) to be inoperable. The EDG was inoperable for an unknown period of time between October 12 and October 30, 2001. This issue was determined to be of very low safety significance based on a phase 2 risk evaluation in accordance with our significance determination process. The other three EDGs and both offsite power sources remained operable during this time period. This finding also affects the Barrier Integrity cornerstone.

Inspection Report# : [2001010\(pdf\)](#)

G

Significance: Aug 18, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

UNITS 2 AND 3 HIGH PRESSURE COOLANT INJECTION SUCTION FROM THE TORUS CHECK VALVES (CHK-2-23B-61 AND CHK-3-23B-61) NOT TESTED PER ASME OM CODE INSERVICE TESTING (IST) REQUIREMENTS.

A Non-cited violation of 10 CFR 50.55a(f)(4)(ii) and Technical Specification 5.5.6, "Inservice Testing Program" was identified for failure to test the Unit 2 and Unit 3 high pressure coolant injection (HPCI) torus suction check valves for seat leakage in the reverse flow direction. Excessive leakage of these check valves could render the HPCI system inoperable during certain small-break loss of coolant accident scenarios. This issue was determined to be of very low safety significance since the respective high pressure coolant injection system remained operable and no actual loss of function occurred.

Inspection Report# : [2001006\(pdf\)](#)

G

Significance: Aug 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

EMERGENCY DIESEL GENERATORS BEING IN A CONDITION OUTSIDE THE DESIGN BASIS FOR OPERATION.

Peach Bottom Technical Specifications (TS) Section 3.8.1 requires all EDGs to be capable of supplying onsite Class 1E electrical power, and TS Section 3.8.1.F requires all but one EDG to be restored to operable status within two hours if two or more EDGs are inoperable. During the summer of 1999, three of the four EDGs were inoperable due to cross-flows between the jacket water coolers and the intake air coolers for a maximum of approximately 25 continuous hours. The corrective actions for this violation were already in the licensee's corrective action program (PEP report I0011529). This is being treated as a Non-Cited Violation.

Inspection Report# : [2001006\(pdf\)](#)

G

Significance: Aug 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

PROCEDURAL INADEQUACIES WITH SO 53.7.D, "RESPONSE TO A LOSS OF #343 OFF-SITE STARTUP SOURCE" IDENTIFIED DURING THE LOSS OF ONE OFFSITE POWER SOURCE.

Technical Specification 5.4.1 requires written procedures be established, implemented, and maintained covering activities listed in Regulatory Guide 1.33. Regulatory Guide 1.33 includes abnormal conditions such as loss of electrical power sources. In June 2001, the procedure, SO 53.7.D, "Response to a Loss of #343 Off-Site Startup Source," Revision 24 did not direct proper alignment of emergency bus breaker switches as required to maintain automatic emergency diesel generator power to all emergency buses. Therefore, equipment powered by these buses would not fulfil their safety function to mitigate the consequences of an accident. The corrective actions for this violation were already in the licensee's corrective action program (Condition Report (CR)# 00061124). This is being treated as a Non-Cited Violation.

Inspection Report# : [2001006\(pdf\)](#)

G

Significance: Jun 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Failure to Adequately Implement a High Pressure Coolant Injection Surveillance Test Procedure for a Minimum Flow Valve Stroke Time - Unit 3

Technical Specification 5.4.1 requires written procedures be established, implemented and maintained covering activities listed in Regulatory Guide 1.33. Regulatory Guide 1.33 includes surveillance tests on emergency core cooling systems such as the high pressure coolant injection system (HPCI). In March 2001, a required stroke time for a Unit 3 HPCI system minimum flow valve was not identified as being in the alert range during surveillance testing and, therefore, it was not properly evaluated as required by the surveillance test procedure, ST-O-023-301-3. The issue is documented in Exelon's corrective action program as PEP I0012794.

Inspection Report# : [2001005\(pdf\)](#)

G

Significance: Jul 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

SAFETY SYSTEM DESIGN AND PERFORMANCE CAPABILITY

The inspectors identified a non-cited violation for failure to properly conduct inservice tests of the standby liquid control system tests. Specifically, the test procedure did not mandate a two-minute wait, as required by the applicable code, before pump flow and pressure measurements were recorded. PECO demonstrated that the failure to wait the required two-minute period did not affect system operability. This finding had very low safety significance because the two-minute wait period was only to assure that a valid assessment of the pump performance under normal operating conditions was obtained.

Inspection Report# : [2000005\(pdf\)](#)**Barrier Integrity**

G

Significance: Nov 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

UNIT 3 INADVERTENT UNPLANNED VESSEL INVENTORY REDUCTION DURING THE 3R13 OUTAGE

The inspectors identified a Non-Cited violation of Technical Specification 5.4, "Procedures" for inadequate procedural controls during the activity to flush the Unit 3 residual heat removal (RHR) system crosstie piping. The procedural control inadequacies contributed to a failure to isolate the Unit 3 'B' train of RHR from the reactor coolant system. The failure to isolate the 'B' train of RHR from the reactor coolant system resulted in an unexpected decrease in reactor vessel water level from approximately + 200 inches to approximately + 158 inches over a four and a half minute period. This issue was determined to be of very low safety significance since the low reactor water level alarm, the automatic RHR shutdown cooling isolation, and automatic RHR and core spray reactor vessel injection functions remained operable during this event. Over 27 feet of water still remained above the top of active fuel. Additionally, regional senior reactor analysts determined that the conditional core damage probability for this event was less than 1E-7.

Inspection Report# : [2001009\(pdf\)](#)

G

Significance: Nov 09, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

JET PUMPS POST-MAINTENANCE TESTING INADEQUACIES

A non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, for failure to determine the cause of inadvertently exceeding 100% core flow during the Unit 3 startup, and to take corrective actions to preclude recurrence. During the startup, the licensee inadvertently exceeded 100% core flow for a period of ninety minutes. The finding was determined to be of very low safety significance because maximum core flow reached 106.3%, which was below the design core flow limit of 110%. As a result, barrier integrity was not challenged.

Inspection Report# : [2001007\(pdf\)](#)

G

Significance: Jun 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Failure to Use Applicable Design Criteria from Calculations in Acceptance Limits for 'A' Standby Gas Treatment Heater Capacity Testing - Common

10 CFR 50, Appendix B, Criterion XI, "Test Control," requires, in part, that written test procedures used to demonstrate that structures, systems, and components perform satisfactorily incorporate acceptance limits contained in applicable design documents. During surveillance testing of the 'A' Standby Gas Treatment (SBGT) system per ST-O-09A-230-2 on May 29, 2001, the test procedure did not contain applicable acceptance criteria. Specifically, heater performance testing for the 'A' SBGT system was evaluated using acceptance criteria based on a heater capacity calculation that assumed a balanced three phase circuit. This was not the configuration during this test since one element of the heater circuit was bypassed. This issue is documented in Exelon's corrective action program as PEP 10012657.

Inspection Report# : [2001005\(pdf\)](#)**Emergency Preparedness**

Significance: SL-III Nov 17, 2001

Identified By: NRC

Item Type: VIO Violation

INOPERABLE OFF-SITE SIRENS NOT IDENTIFIED DUE TO FALSIFIED MAINTENANCE AND TESTING RECORDS AND INSTALLATION OF JUMPERS THAT BYPASSED SIREN FAILURE DETECTION CIRCUITRY

A Severity Level III - Notice of Violation, (EA-01-188) was issued in an NRC letter dated October 23, 2001. During an investigation initiated by the NRC Office of Investigations on September 27, 2000, violations of NRC requirements were identified. A. A violation of 10 CFR 50.9 was identified due to records of routine maintenance and testing performed on sirens in various locations surrounding Limerick Generating Station (LGS) and Peach Bottom Atomic Power Station (PBAPS) not being complete and accurate in all material respects. Specifically, from April/May 2000 until October 2000, two former Exelon Infrastructure Services (EIS) contractors falsified numerous "Siren Report - Routine Maintenance Checklist" records indicating that they had completed all of the routine maintenance steps, when, in fact, they had not. B. A violation of 10 CFR 50.47(b)(5) was identified when for an undetermined period of time prior to October 2000, 10 of 97 sirens surrounding PBAPS and 4 of 165 sirens surrounding LGS contained jumpers that bypassed failure detection circuitry. As a result, a false indication was provided that the sirens were working properly when, in fact, they were not. One of the former EIS contractors admitted to installing approximately ten jumper wires in LGS and PBAPS siren boxes between November 1999 and September 2000 to specifically bypass the failure detection circuitry. Installation of the jumpers compromised the ability to detect, for certain sirens, any malfunction of this system which is used to provide early notification to the populace surrounding PBAPS and LGS. The siren system was compromised in that the jumpers prevented detection of certain inoperable sirens, which would have delayed, or possibly precluded you from taking compensatory actions to alert certain areas of the local populace in the event of an emergency. The safety significance of the violations was low because over 95% siren coverage of the population in the vicinity of LGS and PBAPS was maintained. .

Inspection Report# : [2001009\(pdf\)](#)

Significance: N/A Aug 02, 2001

Identified By: NRC

Item Type: FIN Finding

SUPPLEMENTAL INSPECTION (95001) IN RESPONSE TO WHITE PERFORMANCE INDICATOR FOR THE ALERT NOTIFICATION SYSTEM THAT OCCURRED IN THE THIRD QUARTER OF CY 2000

This supplemental inspection (95001) was performed by the NRC to assess the licensee's evaluation associated with a White Performance Indicator (PI) for the Alert Notification System (ANS) Reliability. In the third quarter of 2000, the Peach Bottom ANS Reliability PI was White (Green in the prior quarter). The inspector determined that the licensee had performed a thorough evaluation in response to the PI's change in color. The licensee identified that the change in the PI was due to installed jumper wires which bypassed failure detection circuitry. The licensee identified this issue, determined the cause and developed comprehensive corrective actions to address the causes and prevent recurrence. The licensee's root cause evaluation identified the contributing factors to be: (1) a lack of licensee oversight of contractor and utility personnel; (2) failure to enforce contractual requirements; (3) an over reliance on the failure detection system; and (4) inadequate self- assessment. The licensee's corrective actions to prevent recurrence included: (1) training for contractors regarding specification content and methodologies; (2) modification of contract content requirements to specify supervisory oversight; (3) development of guidelines for monitoring contracts concerning work performed independent of direct utility supervision; and (4) development of a siren program manual that will include self- assessment criteria and activities. The inspector determined that the licensee's corrective actions were appropriate and that the ANS Reliability PI had changed from White to Green for the first quarter of 2001.

Inspection Report# : [2001012\(pdf\)](#)



Significance: G Aug 02, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE RESOLUTION 10 CFR 50.54(t) AUDIT FINDING RELATED TO THE INTERFACE BETWEEN THE LICENSEE AND LOCAL GOVERNMENT/AGENCIES.

The inspector determined that the 2000 EP quality assurance audit failed to evaluate and document the EP staffs' interface problems with State and local governments in accordance with 10 CFR 50.54(t) requirements even though deficiencies were identified. The finding was considered more than minor because there was a potential impact on public safety in that the offsite agencies are an integral part of the response to a radiological emergency. However, the inspector determined the licensee failed to implement a regulatory requirement which is not considered a failure to meet a planning standard as defined in Appendix B, Manual Chapter 0609. Also, there was no evidence of an actual interface problem affecting response capabilities. Therefore, this finding was determined to be of very low safety significance (Green). The inspector identified this as a non-cited violation for failing to properly document and assess offsite agency concerns as required by 10 CFR 50.54(t).

Inspection Report# : [2001012\(pdf\)](#)



Significance: G Aug 02, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

ANNUAL MEDIA TRAINING NOT CONDUCTED

The inspector identified that the licensee had not conducted the annual media training for the year 2000 as required per Section 6.1.4 of the licensee's Emergency Response Plan (ERP). This finding was more than minor because there was a potential impact on public safety in that the information to the general public via the media needs to be disseminated accurately to avoid confusion. However, it was of very low safety significance because, during this time period, the issue was limited in scope, the licensee had conducted the 2000 training in March of 2001, and

the issue is viewed as an implementation problem. The inspector identified this as a non-cited violation for the licensee failing to conduct training according to the ERP and as required per 10 CFR 50.54(q) and 10 CFR Part 50, Appendix E.IV.F.1.

Inspection Report# : [2001012\(pdf\)](#)



Significance: Aug 02, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

ANNUAL RADIOLOGICAL MONITORING TRAINING NOT CONDUCTED

The inspector identified that the licensee had not conducted the annual radiological monitoring drill for the year 2000 which would include the actual collection and analyses of environmental samples as described in the Emergency Response Plan (ERP) Section 6.2.7. This finding was more than minor because there was a potential impact on public safety in that the licensee conducts drills or training in order to maintain proficiency in case an actual radiological emergency occurs. However, it was of very low safety significance because there was no evidence of a loss of proficiency for the group of responders and the issue is viewed as an implementation problem. The inspector identified this as a non-cited violation for the licensee not conducting drills according to the ERP and as required per 10 CFR 50.54(q) and 10 CFR Part 50, Appendix E. IV.F.1.

Inspection Report# : [2001012\(pdf\)](#)



Significance: Jul 10, 2001

Identified By: NRC

Item Type: VIO Violation

FAILURE TO MAINTAIN PA/EVACUATION ALARM SYSTEM FOR PERFORMING THE DESIGNATED EMERGENCY PREPAREDNESS EVACUATION FUNCTION.

By letter on August 22, 2001, the NRC issued the final significance determination and violation. The inspectors identified a violation of an emergency planning standard and requirement in that the power block's public address (PA)/evacuation alarm system was degraded from 1992 to 2000 and, once repaired, it continued to be degraded with breaker problems. Accordingly, the system would not have been able to meet its emergency planning function. Requirements 10 CFR 50.54(q), emergency planning standard 10 CFR 50.47b(8), and Appendix E Section IV.E.9 require that onsite emergency communication systems be maintained and have a backup power source. During the period of 1992-2000, the PA/evacuation alarm system was not functioning correctly, in that up to 47% of the speakers (as of April 1999) were either inaudible or degraded to the point in which an individual would not be able to clearly hear instructions. From January 19 to February 13 and March 20 to April 17, 2001, the system would have become nonfunctional after 49 seconds of operation because the system had been operating on the backup power breaker and the breaker would have tripped. On February 13 and April 17, 2001, the PA/evacuation alarm system was nonfunctional for the periods of 4.5 hours and 1.5 hours, respectively, because both the primary and backup breakers had tripped resulting in a loss of power to the system. This issue was assessed using the emergency preparedness Significant Determination Process (SDP) described in NRC Inspection Manual Chapter 0609, Appendix B, and characterized as a White finding. The finding was of low to moderate safety significance because the failure to maintain the emergency onsite communication system without adequate compensatory measures or without a backup power source resulted in an emergency preparedness function not being met. The function would not have been met, in that the licensee would not properly inform and alert onsite personnel of protective actions and would unnecessarily delay a site evacuation. (EA-01-148) A supplemental inspection (95001) was performed by the NRC and documented in NRC Inspection report 05000277/2001-014 to assess the licensee's evaluation and corrective actions associated with the violation. The inspector determined that the licensee had performed a thorough evaluation, have taken immediate corrective actions, and continue to address the long term corrective actions in response to this White finding. The licensee determined the cause and developed comprehensive corrective actions to address the causes and prevent recurrence. The licensee's root cause evaluation identified the contributing factors to be: (1) routine testing of the system was suspended in 1992; (2) no recognition of the importance of the audibility of the speakers in carrying out the requirements of the Emergency Plan (E-Plan); (3) less than adequate modification performed in the early 1990's due to not considering the operating loads required for the plant evacuation notifications; (4) less than adequate assessment of the impact to the emergency planning requirements when the breakers were discovered to be tripped.

Inspection Report# : [2001011\(pdf\)](#)

Inspection Report# : [2001014\(pdf\)](#)

Occupational Radiation Safety



Significance: Sep 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN A BARRICADE AT A POSTED HIGH RADIATION AREA/HIGH CONTAMINATION AREA ON THE UNIT 3 TURBINE FLOOR PER T.S. 5.7.1.

A Non-cited violation of Technical Specification 5.7.1, "High Radiation Area with Dose Rates Not Exceeding 1.0 rem/hour (at 30 centimeters from the radiation sources or from any surface penetrated by the radiation)" was identified. The non-cited violation was for failure to appropriately barricade a posted high radiation area on the Unit 3 turbine floor. The high radiation area was not appropriately barricaded because the normally

locked door to the area was open and the health physics technician assigned to restrict access to the high radiation area while the door was open was inattentive to his duties. The failure to properly restrict access through this door could allow site personnel to inadvertently enter the high radiation area on the main turbine deck and receive unintended dose. This issue was determined to be of very low safety significance since it did not constitute an ALARA finding, no unauthorized persons entered the area, no personnel were overexposed, and there was no substantial potential for exposure above the regulatory limits.

Inspection Report# : [2001008\(pdf\)](#)

Public Radiation Safety



Significance: May 20, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

SHIPMENT RECORDS AND DOCUMENTATION

The NRC identified two examples of failure to ensure proper closure of radioactive material shipping packages. The first example involved an April 25, 2000, shipment during which an incorrect procedure was used to secure the primary lid on a shipping cask being prepared for shipment. The procedure provided incorrect guidance for calculation of torque wrench settings used for closure of the cask. The second example involved a December 8, 1999, shipment during which PECO Nuclear did not ensure accuracy of leak testing equipment used to prepare a shipping cask. The two examples involved matters that had very low risk significance because no radiation limits were exceeded and there was no actual public health and safety consequences. The inspectors identified a non-cited violation of 10 CFR 71.5.

Inspection Report# : [2000002\(pdf\)](#)

Physical Protection



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Access Control

The inspectors identified a non-cited violation of 10 CFR 73.55 (b)(3) because on at least two occasions required personnel were not notified within the specified time to remove terminated individuals from the access authorization list. The finding was of very low safety significance because there was no malevolent act, no actual intrusion occurred, and there have not been greater than two similar findings in the past four quarters.

Inspection Report# : [2001003\(pdf\)](#)

Miscellaneous

Significance: TBD Mar 10, 2000

Identified By: NRC

Item Type: FIN Finding

HEALTH PHYSICS SUPPORT

The licensee's plans and preparations for controlling radiological activities for the ISFSI were extensive and detailed. A specific radiation work permit included appropriate radiological controls and a review was conducted to maintain dose as low as is reasonably achievable (ALARA). A health physics supervisor and several technicians were dedicated to the ISFSI project. They were actively involved with the dry-run activities, provided pre-job briefings, and projected radiation conditions to the ISFSI work staff.

Inspection Report# : [2000004\(pdf\)](#)

Significance: TBD Mar 10, 2000

Identified By: NRC

Item Type: FIN Finding

MANAGEMENT, ORGANIZATION, RESPONSIBILITIES, SELF-ASSESSMENTS, AND CORRECTIVE ACTIONS

The operational procedures for the loading, unloading, and transferring activities associated with the TN-68 cask storage system included the appropriate acceptance criteria and met ISFSI program needs and regulatory requirements. The procedures were highly detailed, and reviewed and approved in accordance with the licensee's administrative program for document control.

Inspection Report# : [2000004\(pdf\)](#)

Significance: TBD Mar 10, 2000

Identified By: NRC

Item Type: FIN Finding

PROCEDURES, DOCUMENT CONTROLS, & RECORDS

The operational procedures for the loading, unloading, and transferring activities associated with the TN-68 cask storage system included the appropriate acceptance criteria and met ISFSI program needs and regulatory requirements. The procedures were highly detailed, and reviewed and approved in accordance with the licensee's administrative program for document control.

Inspection Report# : [2000004\(pdf\)](#)

Significance: N/A Feb 16, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

LICENSEE DID NOT ADHERE TO RADIATION PROTECTION PROCEDURES

Technical Specification 6.11 requires that the licensee implement radiation protection procedures. Procedure HP-C-310 requires workers to notify radiation protection personnel of radiological problems and follow written and oral radiation protection guidance including notifying radiation protection upon an electronic dosimetry alarm. During early January 2002, at least 5 individuals experienced dosimetry alarms and did not contact radiation protection. The matter was addressed by various corrective actions and entered into the corrective action process (CR No. 93464).

Inspection Report# : [2001015\(pdf\)](#)

Significance: N/A Feb 16, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

LICENSEE DID NOT ADHERE TO A SURVEILLANCE TEST PROCEDURE

Technical Specification 5.4.1 requires written procedures be established, implemented, and maintained covering activities listed in Regulatory Guide 1.33. Regulatory Guided 1.33 includes procedures for performing surveillance tests on plant equipment. Contrary to the above, on November 16, 2001, operators did not verify compliance with Technical Specification 3.5.1 as required by ST-I-010-100, "Residual Heat Removal (RHR) Loop Logic System Functional Test." Specifically, with the 3'A' loop of RHR inoperable for automatic the low pressure coolant injection, on three separate occasions the operators did not verify compliance with Technical Specification 3.5.1. The first occurred when the 3'B' RHR pump was also inoperable for approximately 30 minutes, the second was when the 3'D' RHR pump was also inoperable for approximately 30 minutes and the third was when the 3'A' core spray loop was also inoperable for approximately 40 minutes. Although all three occasions were contrary to the requirements of Technical Specification 3.5.1, technical specifications were not violated since no required actions were missed during the time frames in which the additional subsystems were inoperable. The licensee entered this issue into their corrective action program as CR 00083213. This is being treated as a Non-Cited Violation.

Inspection Report# : [2001015\(pdf\)](#)

Significance: N/A Nov 09, 2001

Identified By: NRC

Item Type: FIN Finding

SUMMARY CONCLUSION REGARDING THE EFFECTIVENESS OF THE PROBLEM IDENTIFICATION AND RESOLUTION (PI&R) PROGRAM FROM THE PI&R INSPECTION

The team concluded that, based on the review of a selected sample, the overall implementation of the corrective action program at Peach Bottom Atomic Power Station, Units 2 & 3, was acceptable. In general, problems were identified at an appropriate level and entered into the corrective action program. Issues were adequately prioritized and evaluated, and the evaluations were of adequate depth to identify the causes and appropriately broad in considering the extent of condition. The corrective actions were reasonable and adequately implemented. Nevertheless, the team identified instances where the licensee missed opportunities to identify and enter problems into the condition report process. In one instance, the issue resulted in a Green finding that was also a non-cited violation.

Inspection Report# : [2001007\(pdf\)](#)

Significance: N/A Dec 22, 2000

Identified By: NRC

Item Type: FIN Finding

IDENTIFICATION AND RESOLUTION OF PROBLEMS

PECO was effective at identifying problems and entering them into their problem identification and resolution (PI&R) programs. Workers were not reluctant to input safety issues into the station's PI&R programs. Few deficiencies were identified by external organizations, including the NRC. PECO identified problems in a timely manner, commensurate with their significance and ease of discovery. No instances were identified in which conditions adverse to quality were being handled outside the corrective action program. PECO identified and implemented acceptable corrective actions for individual problems or issues. The corrective actions considered the significance of the issue or problem, extent of condition, generic implications, common cause, and previous occurrences. PECO identified root and contributing causes for significant conditions adverse to quality and adequately completed or scheduled completion of corrective actions.

Inspection Report# : [2000013\(pdf\)](#)

Significance: N/A Dec 22, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

INCORRECT LICENSE APPLICATION SUBMITTED TONRC

NO COLOR - The team identified a non-cited Severity Level IV violation of 10 CFR 55.31(a)(4) because an operator license application was submitted to the NRC in August 1999 with incorrect information. The application was incorrect because it indicated that the individual completed all required training even though the emergency preparedness portion of his required training was not completed until May 2000 (approximately eight months after the individual had been licensed). When evaluating this issue according to NRC Manual Chapter 0610*, Appendix B, it did involve extenuating circumstances in that the issue potentially impacted the NRC's ability to perform its regulatory function. The team's evaluation of the apparent cause indicated a problem between the emergency preparedness and operator training organizations, and limited to one individual. The issue was documented in PECO's corrective action program as Performance Enhancement Program Issue I0012084.

Inspection Report# : [2000013\(pdf\)](#)

Significance: N/A Dec 22, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

INACTIVE LICENSED OPERATOR PERFORMED THE FUNCTIONS OF A LICENSED OPERATOR

10CFR55.53 requires performance of operator duties during five 12-hour shifts in a prior calendar quarter to maintain an active license in the current quarter. An operator performed the functions of a licensed operator during four-12 hour shifts in the third quarter of 2000 and thus became inactive. The individual performed the functions of a reactor operator for fifteen 12-hour shifts in the fourth quarter of 2000 without having completed the required actions to restore the individual's license to an active status. This item is PEP I0012046 in PECO's corrective action program.

Inspection Report# : [2000013\(pdf\)](#)

Significance: SL-IV Aug 19, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

PACKING GLAND FOLLOWER FAILURES ON ROOT ISOLATION VALVES

PECO failed to determine the cause of the May 28, 2000 cracking of the packing gland follower which caused leakage of contaminated reactor coolant system water outside of primary containment, a significant condition adverse to quality, and take corrective actions to prevent repetition. The lack of corrective actions from the May 28, 2000 cracking of the packing gland follower contributed to the repetitive event on August 7. The August 7 cracking of the packing gland follower resulted in leakage of contaminated reactor coolant outside of primary containment and an automatic reactor shutdown and primary containment isolation valve closures. The inspectors identified a Severity Level IV non-cited violation of 10 CFR 50, Appendix B, Criterion XVI. This issue is documented in PECO's corrective action program as PEP 10011575.

Inspection Report# : [2000008\(pdf\)](#)

Last modified : April 01, 2002