Salem 1

Initiating Events

Significance: G Apr 01, 2000
Identified By: Self Disclosing
Item Type: FIN Finding
A TECHNICIAN APPLIED A JUMPER TO THE WRONG RELAY CONTACTS DURING ON-LINE MAINTENANCE, CAUSING A COMPLETE LOSS OF ALL CIRCULATING WATER TRAVELING SCREENS
A maintenance technician applied a jumper to the wrong contacts on a protective relay during a planned on-line maintenance activity associated with the 12B circulating water pump breaker. This error resulted in the complete loss of all circulating water system traveling water screens (TWSs). The safety significance of this event was very low because the TWSs were restored within five minutes and there was no observable affect on circulating water flow to the main condenser.
Inspection Report# : 2000002*(pdf)*

Significance: G Nov 10, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
PSEG NUCLEAR FAILED TO PROPERLY CONTROL TRANSIENT COMBUSTIBLE MATERIALS WITHIN THE UNIT 1 SPENT FUEL POOL
Failure to properly control transient combustible materials located within the Unit 1 spent fuel pool building as required by fire protection program procedure, NC.NA-AP.ZZ-0025(Q), revision 5, "Operational Fire Protection Program." This finding was evaluated using the fire protection significance determination process and found to be of very low risk significance since the problem would not have affected the fire mitigation defense in depth elements involving detection, suppression or fire barriers.
Inspection Report# : 2001010*(pdf)*

Significance: N/A Mar 23, 2001
Identified By: NRC
Item Type: FIN Finding
SUPPLEMENTAL INSPECTION TO REVIEW THE CORRECTIVE ACTIONS IN RESPONSE TO THE SALEM UNIT 1 UNPLANNED SCRAM PERFORMANCE INDICATOR CROSSING THE WHITE THRESHOLD DURING THE 4TH QUARTER OF 2000
This supplemental inspection was performed in accordance with Inspection Procedure 95001 to assess PSEG's evaluation associated with the unplanned reactor scram performance indicator (PI) crossing the white threshold during the 4th quarter of 2000. The identification, evaluation, and corrective actions for each of the individual trips was appropriate. The inspectors determined that PSEG performed a comprehensive common cause analysis of the performance deficiencies related to this PI. While the analysis did not identify a definitive common cause, several influencing factors were identified regarding the Salem Unit 1 trips and associated white PI. These factors included human performance issues, equipment failure issues, procedure issues, and preventive maintenance issues. These issues were documented in PSEG's corrective action program and addressed in a comprehensive corrective action plan. PSEG took appropriate actions in addressing the performance deficiencies contributing to this white PI. As such, the NRC removed this issue from consideration of future agency actions, per the Action Matrix, in accordance with Inspector Manual Chapter 0305.
Inspection Report# : 2001005*(pdf)*

Significance: G Oct 10, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW PROCEDURE FOR PLACING A MIXED BED DEMINERALIZER IN SERVICE, RESULTING IN INADVERTENT REDUCTION IN RCS BORON CONCENTRATION OF 75 PPM WHILE SHUTDOWN
PSEG operators failed to properly implement the procedure for placing a mixed bed demineralizer in service which resulted in an inadvertent reduction in reactor coolant system boron concentration of approximately 75 ppm. The safety significance of this event was very low based on the absence of any adverse consequences during the event and the TS limit for shutdown boron concentration not having been exceeded.
Inspection Report# : 1999008*(pdf)*

Significance: G Oct 10, 1999
Identified By: NRC

Item Type: NCV NonCited Violation
TWO EXAMPLES OF OPERATOR FAILURES TO FOLLOW SURVEILLANCE TEST PROCEDURES, RESULTING IN WRONG CHANNEL OR WRONG UNIT EQUIPMENT OPERATION
Two examples of licensed reactor operators failing to properly implement surveillance test procedures resulted in the operation of: (1) a switch in the wrong Unit 1 safeguards equipment cabinet, and (2) a charging system flow control valve on the wrong Salem unit. The safety significance of these examples was very low - in the first case, the plant was shutdown and there were no consequences to the error; in the second case, only one cornerstone was affected and (in the worst case) the error would have resulted in an uncomplicated reactor trip.
Inspection Report# : 1999008*(pdf)*

Significance: G Aug 29, 1999
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY CONTROL THE REMOVAL OF ELECTRICAL CABLE FIRE WRAP MATERIAL
During the implementation of design change package 1EE-0436, some fire wrap was inappropriately removed such that UFSAR-described cable separation criteria were not met. The risk significance of this issue was low because only one train of safe shutdown equipment was affected. This issue represented a non-cited violation of 10 CFR 50, Appendix B Criterion III. This issue was characterized as a "green" finding as the risk significance of this issue was very low because only one train of safe shutdown equipment was affected.
Inspection Report# : 1999007*(pdf)*

Significance: G Jul 11, 1999
Identified By: NRC
Item Type: FIN Finding
FIRE PROTECTION/BARRIERS
PSEG maintained appropriate control of combustible material and ignition sources in inspected areas. In general, impaired fire barriers were clearly tagged and documented in the corrective action program (CAP). However, the inspectors discovered some minor deficiencies such as a fire door which would not completely close without operator assistance. The minor violation associated with the fire door which would not close completely without operator assistance was classified as a green finding due to its very low safety significance.
Inspection Report# : 1999005*(pdf)*

Mitigating Systems

Significance: G Dec 30, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY ALIGN THE BREAKER FOR A UNIT 1 SERVICE WATER PUMP
Operators failed to properly align the breaker for a Unit 1 service water pump following maintenance. This resulted in the pump failing to start approximately 11 days after being returned to service. Also, the corrective action investigation was not thorough and did not recognize that the pump may have been inoperable for these 11 days. The failure to properly align the breaker was a non-cited violation. The finding was of very low safety significance (Green) because redundant mitigating equipment was available during the periods when the pump was unavailable.
Inspection Report# : 2000010*(pdf)*

Significance: G Nov 11, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO SCHEDULE AND PERFORM PREVENTIVE MAINTENANCE FOR A TURBINE DRIVEN AUXILIARY FEEDWATER MODIFICAITON
PSEG Nuclear did not perform the specified preventive maintenance (PM) tasks for the new equipment associated with the turbine driven auxiliary feedwater pump enclosure modification at both units. This problem resulted in a credible impact on safety-related equipment which could have affected the availability and reliability of the auxiliary feedwater system. The failure to properly perform PM tasks for new equipment associated with modification 2EC-3522 as required by Procedure NC.WM-AP.ZZ-0003(Q), Rev 0, "Regular Maintenance Process," was considered to be a non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings." The issue was determined to be of very low risk significance using the Significance Determination Process phase 1 screening because no actual equipment failures were attributed to the missed PMs.
Inspection Report# : 2000009*(pdf)*

Significance: W Feb 07, 2000
Identified By: NRC
Item Type: VIO Violation
THE CARBON DIOXIDE TESTS FOR THE UNITS 1 & 2 4,160 VAC SWITCHGEAR ROOMS DID NOT REACH OR MAINTAIN THE REQUIRED CO2 CONCENTRATION OF 50%
PSEG did not ensure that the carbon dioxide concentration tests for the Units 1 & 2 4,160 VAC switchgear rooms reached and maintained the required CO2 concentration of 50%. This is a violation of Unit 1 license condition C.5 and Unit 2 license condition 2.C.10. This finding was determined to be WHITE by the significance determination process. The safety significance of this WHITE finding is low to moderate. During the supplemental inspection, performed in accordance with Inspection Procedure 95001, the inspector determined that PSEG had performed a comprehensive evaluation of the failure of the carbon dioxide suppresion system to achieve its design concentration. PSEG is currently working to correct carbon dioxide concentrations for the total flooding fire suppression systems, upgrade electrical raceway fire barrier systems, and convert the 4160v switchgear room fire suppresion systems from manual to automatic. Based on PSEG's acceptable performance in addressing the switchgear room fire suppression system issue, the White finding associated with this issue will only be consdidered in assessing tplant performance for a total of four quarters in accordance with the guidance in NRC Inspection Manual Chapter 0305.
Inspection Report# : 1999010*(pdf)*

Significance: G Feb 07, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
PSEG FAILED TO ENSURE THE CO2 SYSTEMS FOR THE UNITS 1 & 2 4,160 VAC ELECTRIC PENETRATION ROOMS REACHED AND MAINTAINED THE REQUIRED CO2 CONCENTRATION
The team identified that the carbon dioxide concentration tests for the Units 1 & 2 electrical penetration areas did not reach or maintain the required CO2 concentration of 50%. This failure is a violation of license conditions for each unit. This finding was evaluated by the significance determination process (SDP) and determined to be GREEN based on the other detection and suppression systems available in the area. The safety significance of this finding is very low.
Inspection Report# : 1999010*(pdf)*

Significance: G Feb 07, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
PSEG FAILED TO ENSURE THAT ONE TRAIN OF EQUIPMENT NECESSARY TO ACHIEVE HOT SHUTDOWN FORM THE EMERGENCY CONTROL STATION IS FREE OF FIRE DAMAGE
PSEG identified a condition in which they failed to ensure that one train of equipment necessary to achieve hot shutdown from the emergency control station is free of fire damage. This is a non-cited violation of Section III.G.1.a of Appendix R. This issue was evaluated by the SDP and found to be within the licensee's respone band. (GREEN) The safety significance of this finding is very low.
Inspection Report# : 1999010*(pdf)*

Significance: G Feb 07, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
PSEG IDENTIFIED A CONDITION IN WHICH A FIRE COULD DAMAGE CABLES SUCH THAT THE POWER OPERATED RELIEF VALVE WOULD OPEN AND THE ASSOCIATED BLOCK VALVE COULD NOT BE CLOSED.
PSEG identified a condition in which a fire could damage cables such that the power operated relief valve would open and the associated block valve could not be closed. The failure to protect one train of equipment necessary to achieve hot shutdown is a violation of III.G.1.a of Appendix R. This finding was evaluated by the SDP and determined to be GREEN. The safety significance of this finding was very low.
Inspection Report# : 1999010*(pdf)*

Significance: G Feb 09, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO DOCUMENT AND MAINTAIN QUALITY RECORDS OF EMERGENT TROUBLESHOOTING AND MAINTENANCE ACTIVITIES ON THE CONTROL CIRCUITRY FOR THE 1B EDG
PSEG Nuclear maintenance failed to document and maintain records of emergent troubleshooting and maintenance activities on the control circuitry for the 1B EDG. PSEG Nuclear also failed to maintain records of a September 2000 internal inspection of the 12 charging pump speed increaser. These two examples of PSEG Nuclear's failure to maintain complete and adequate inspection and maintenance records were a non-

cited violation of Technical Specification 6.10.1.b and 10 CFR 50, Appendix B, Criterion XVII, Quality Assurance Records. The findings were evaluated using the significance determination process (SDP) and considered to be of very low risk significance because the failure to maintain the records did not affect the availability of the mitigating systems.
Inspection Report# : 2001012*(pdf)*

Significance: G May 19, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY ASSESS THE RISK ASSOCIATED WITH THE REMOVAL OF THE 1C 125 VOLT BATTERY FROM SERVICE TO CONDUCT A PLANNED MAINTENANCE ACTIVITY
10 CFR 50.65 (a)(4) requires that "before performing maintenance activities, the licensee shall assess and manage the increase in risk that may result from the proposed activities." On April 20, 2001, PSEG Nuclear did not properly evaluate the risk associated with the removal of the 1C 125 volt battery from service to conduct a planned maintenance activity.
Inspection Report# : 2001006*(pdf)*

Significance: G Mar 31, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY ASSESS THE RISK ASSOCIATED WITH THE SIMULTANEOUS REMOVAL OF THE 1 SERVICE WATER BAY AND THE 1B EMERGENCY DIESEL GENERATOR FROM SERVICE
The licensee failed to properly assess the risk associated with the simultaneous removal of the 1 service water bay and the 1B emergency diesel generator from service. This finding was evaluated using the significance determination process and found to be GREEN (of very low risk significance) due to the relatively short duration (about 3 hours) that both systems were out-of-service. The failure to perform an adequate risk assessment prior to removal of these systems from service was a non-cited violation.
Inspection Report# : 2001003*(pdf)*

Significance: G Feb 10, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
THE 12 COMPONENT COOLING WATER PUMP IMPELLER WAS UNDER-FILED DURING MAINTENANCE WITHOUT APPROPRIATE DESIGN CONTROLS.
The 12 component cooling water pump was underfiled during maintenance without appropriate design controls. During maintenance on the 12 component cooling water (CCW) pump, impeller filing removed mass from the impeller, changed internal impeller and volute dimensions and clearances, changed the impeller blade angle, and changed the pump capacity. The filing was conducted with a maintenance order rather than the modification process, as required by station administrative procedures. The issue had a credible impact on safety, since this modification of a safety-related component outside of the approved modification process presented the risk that undocumented, unanalyzed, or procedurally uncontrolled dimensional changes could have degraded pump performance characteristics, such as net positive suction head, starting current or pump runout with their attendant impact on safety. Since only the mitigating system cornerstone was affected and this is a design qualification deficiency, the finding is considered to be of very low safety significance. Failure to control the filing of the 12 CCW pump impeller in accordance with administrative procedure requirements was considered a non-cited violation.
Inspection Report# : 2000011*(pdf)*

Significance: G Feb 10, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
LICENSEE IDENTIFIED THAT SAFETY-RELATED VENTILATION DAMPER SPRING WAS MODIFIED DURING MAINTENANCE WITHOUT APPROPRIATE DESIGN CONTROLS
10 CFR 50, Appendix B, Criterion III, Design Control, requires that measures be established for the selection and review for suitability of application of parts that are essential to the safety-related functions of structures, systems and components. PSEG Nuclear identified that while repairing Unit 1 auxiliary building ventilation excess flow damper, S1ABV-1ABS8 under Order 60014824, a spring that assists in damper actuation was modified without the proper engineering documentation. This was documented in the corrective action program as Notification 20052729.
Inspection Report# : 2000011*(pdf)*

Significance: G Sep 01, 1999
Identified By: NRC

Item Type: NCV NonCited Violation
INADEQUATE ACCEPTANCE CRITERIA IN SURVEILLANCE TEST PROCEDURES
The acceptance criteria in the auxiliary feedwater (AFW) pump surveillance test procedures was inadequate since it did not ensure that the pump performance was capable of meeting accident analysis performance or pump operability criteria found in the Unit 1 and 2 Technical Specifications. This issue was considered potentially significant due to the allowable degraded core cooling capability associated with the established AFW pump minimum performance acceptance criteria. This issue has been entered into PSEG Nuclear's corrective action program (CAP). The issue was considered "green" in the significance determination process since it did not have an immediate impact on AFW system operability as determined by an evaluation of recent pump performance.
Inspection Report# : 1999006*(pdf)*

Significance: G Sep 01, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
MULTIPLE EXAMPLES OF INEFFECTIVE IMPLEMENTATION OF THE CORRECTIVE ACTION PROGRAM
The team identified some instances where PSEG Nuclear did not effectively implement the corrective action program (CAP): 1) A prior performance weakness resulted in a governor control system needle valve setting for the 23 AFW pump turbine that was not optimal for actual operating conditions; 2) During operation of the 23 AFW pump, the team identified that the turbine outboard bearing temperature exhibited an increasing trend, which represented an operability question, and PSEG Nuclear was not aware of this potential problem. Consequently, this problem was not entered into the CAP; and, 3) Other examples of ineffective implementation of the CAP were identified, including deficiencies not promptly entered into the CAP or not adequately corrected. These issues were considered to be significant in that they indicated an overall CAP weakness since problems were noted in not identifying corrective action items and the lack of timeliness and effectiveness of corrective actions. These issues were considered "green" in the significance determination process because they did not have an immediate impact on AFW system operability and were ultimately included in PSEG Nuclear's CAP.
Inspection Report# : 1999006*(pdf)*

Significance: G Sep 01, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE DESIGN CONTROL CONCERNING REPLACEMENT PARTS FOR POSITIONERS FOR AFW FLOW CONTROL VAVLES
The team found that the positioners for the AFW flow control valves had been maintained with parts that were not qualified for use in safety-related applications. This issue was considered significant since the functionality for valves in a risk significant system was being challenged. The qualification issue was considered "green" in the significance determination process because it did not have an immediate impact on AFW system operability based on an engineering evaluation and the issue was being addressed by PSEG Nuclear's CAP.
Inspection Report# : 1999006*(pdf)*

Significance: G Jul 11, 1999
Identified By: Licensee
Item Type: FIN Finding
CFCU TRAIN UNAVAILABILITY PERFORMANCE CRITERIA
PSEG nuclear personnel properly monitored containment fan cooling unit (CFCU) performance for reliability and unavailability. However, while PSEG's recent change in the CFCU train unavailability performance criteria was acceptable, it was not based on an evaluation of all of the appropriate factors. Also, the goals for the diesel generators were weak in that the cause of the associated unavailability was not addressed. This finding was assessed to be green as a reevaluation by PSEG of the CFCU train unavailability performance criteria using more appropriate factors revealed only a minimal increase in large early release frequency (LERF).
Inspection Report# : 1999005*(pdf)*

Significance: G Jul 11, 1999
Identified By: NRC
Item Type: FIN Finding
INCOMPLETE COMPENSATORY MEASURES FOR DEGRADED EQUIPMENT CONDITIONS
PSEG nuclear operators appropriately assessed three degraded equipment conditions in terms of their impact on the design basis functions of the affected systems. Each of the operability evaluations were completed in a timely manner. However, some of the associated compensatory measures were either incomplete or poorly controlled. This finding was evaluated to be green due to the minor significance of the compensatory measures needed and the absence of NRC requirements in this area.
Inspection Report# : 1999005*(pdf)*

Barrier Integrity

Significance: G Feb 27, 2000
Identified By: NRC
Item Type: FIN Finding
SMALL UNIDENTIFIED LEAK FROM THE CVCS AT UNIT 2 PERSISTED FOR 3 1/2 HOURS BEFORE IDENTIFICATION AND TERMINATION
A small unidentified leak from the chemical and volume control system at Unit 2 persisted for approximately 3 1/2 hours before operators recognized and terminated the condition. PSEG attributed the delays in recognizing the condition, in part, to the fact that two other concurrent evolutions were in progress or had just been completed which effectively masked the indications of a leak, namely volume control tank level and plant ventilation radiation levels. The safety and risk significance of this incident was very low because adequate reactor coolant inventory sources remained available throughout the event and offsite release rates remained well below regulatory limits.
Inspection Report# : 2000001*(pdf)*

Significance: G Sep 30, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
CONTAINMENT SPRAY SYSTEM VALVES HAD NOT BEEN PROPERLY LEAK RATE TESTED AS REQUIRED BY 10 CFR 50, APPENDIX J
10CFR 50, Appendix B, Criterion XVI, requires, in part, that conditions adverse to quality be promptly identified and corrected. Contrary to the above on August 2, 2001, a PSEG Nuclear engineer identified that containment spray system valves (11, 12, 21, and 22 CS10) had not been properly leak rate tested as required by 10CFR50, Appendix J; however, an appropriate operability assessment and corrective actions were not implemented until August 13, 2001.
Inspection Report# : 2001009*(pdf)*

Significance: G May 19, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IMPLEMENT APPROPRIATE CORRECTIVE ACTIONS FOR A DEGRADED MOISTURE BARRIER
PSEG Nuclear did not repair defects that challenged the integrity of the moisture barrier enclosing the containment insulation assembly and liner, and did not evaluate this aspect of the defects. These defects provided a path for moisture to reach inaccessible and uninspected areas of the containment liner. This finding was evaluated using the significance determination process and found to be of very low significance because the containment integrity was not immediately compromised and adverse effects would be long term. The failure to promptly correct this condition adverse to quality was a non-cited violation of 10 CFR 50 Appendix B, Criterion XVI.
Inspection Report# : 2001006*(pdf)*

Emergency Preparedness

Significance: G Nov 28, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
INEFFECTIVE CORRECTIVE ACTIONS IN THE EP AREA INVOLVING THE FAILURE TO MAKE TIMELY EVENT DECLARATIONS DURING EVENTS ON 12/8/98 AND 9/8/99
GREEN. The NRC identified a problem with corrective actions for emergency classifications based on an untimely EP declaration for a Unit 2 event in 12/98 and again during a Unit 1 event in 9/99. Using the SDP, the finding was determined to be White, in that a PI&R problem existed, there was a failure to resolve the problem based on its recurrence, and an EP planning standard (50.47(b)(14)) was involved. In addition, the NRC observed ineffective PSEG efforts to address the problem. However, following a regulatory conference with PSEG in February 2000 during which additional information was provided, this WHITE finding was reclassified as green. The safety significance of this GREEN finding was very low.
Inspection Report# : 1999009*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Significance: G Dec 29, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
FAILURE TO MAINTAIN YEAR 2000 CALIBRATION RECORDS FOR CHEMICAL WASTE BASIN MONITOR (R37) AND UNIT 1 CONTAINMENT FAN COOLER-SW DISCHARGE MONITOR (1R13B)
Technical Specification Section 6.10.d requires that records of surveillance activities, inspections, and calibrations, required by the TSs, be retained for at least five years. The radiological calibration results for the Chemical Waste Basin Monitor (R37) and the Unit 1 Containment Fan Cooler-Service Water Line Discharge Monitor (1R13B) for the year 2000 were not retrievable. PSEG Nuclear placed this issue into its corrective action system as a Notification Report (Notification 20084063). The finding was determined to be of very low safety significance, because the issue did not impair the ability to assess the public dose, and did not result in exceeding public dose limits listed in Appendix I of 10 CFR 50 or 10 CFR 20.1301(d). The issue was not reportable in the Annual Radiological Effluent Report. Further, PSEG Nuclear produced a work record indicating the calibrations had been properly performed.
Inspection Report# : 2001011*(pdf)*

Significance: G Feb 10, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
UNTIMELY AND INEFFECTIVE CORRECTIVE ACTIONS FOR VENTILATION DAMPER DEFICIENCIES WHICH RESULTED IN LOW AUX BUILDING EXHAUST AIR FLOW DUE TO A CLOSED FIRE DAMPER.
Effective and timely corrective actions for ventilation damper deficiencies were not taken and resulted in low auxiliary building exhaust air flow due to a fire damper failing closed. Several previous similar events had demonstrated the susceptibility of damper locking devices. The finding had a credible impact on safety because radiological effluents could have bypassed the auxiliary building ventilation charcoal filter during accident conditions and resulted in a public radiation hazard. The finding was of very low safety significance because the auxiliary building was maintained at negative pressure during the low flow condition and any radioactive release would have been through high efficiency filtration via the normal monitored flowpath. The failure to take timely and effective corrective actions to preclude the recurrence of damper deficiencies was considered a non-cited violation.
Inspection Report# : 2000011*(pdf)*

Significance: G Oct 10, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO REPORT IN RAD. ENV. OP. REPORTS ACTIONS TO PREVENT RECURRENCE OF RAD. ENVIR. AIR SAMPLER OUTAGES
PSEG failed to provide complete information in their 1997 and 1998 Annual Radiological Environmental Operating Reports in that these documents did not describe plans to prevent recurrence of multiple environmental air sampler outages. This issue was characterized as a Non-Cited Violation of TS 3.12.1. The safety significance of this issue was very low because it did not significantly compromise PSEG's ability to assess the environmental impact of continued plant operation.
Inspection Report# : 1999008*(pdf)*

Physical Protection

Significance: G Aug 29, 1999
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CONDUCT PACKAGE SEARCH IN ACCORDANCE WITH SITE SECURITY PLAN
Security personnel did not properly search a hand-carried package prior to granting it unrestricted access to the site protected area (PA). Specifically, guards permitted a plant worker to bypass the x-ray machine and carry a large bag of moving blankets into the PA without a search of the bag's contents. Later examination of the bag's contents yielded no contraband. This incident was characterized as a "green" issue since no contraband was identified in the package which was not searched.
Inspection Report# : 1999007*(pdf)*

Miscellaneous

Significance: N/A Apr 18, 2000
Identified By: NRC
Item Type: FIN Finding
PROBLEM IDENTIFICATION AND RESOLUTION
No significant findings were identified. There was however, some concern regarding the number of human performance errors that have occurred within all departments at the station over the past two years. The team noted that during the inspection, previously identified human performance issues were all rolled up into one station notification that addressed the human performance issue. Along these lines, but under a separate notification, the team noted a roll up of another human performance issue that dealt specifically with station personnel failing to follow procedures. As identified by the licensee and the team, it was determined that ineffective corrective actions, regarding human performance errors, were attributal to some narrowly focused root cause analyses or to poor correlation of causes with corrective actions. These causes were similar to that noted in the training area (exam quality and written test results). Since improvement plans were being developed to address this area as of the end of the inspection, it was too early to assess the resolution to these problems and subsequent corrective actions. Follow up action is warranted in this area.
Inspection Report# : 2000003*(pdf)*

Significance: N/A Mar 23, 2001
Identified By: NRC
Item Type: FIN Finding
PROBLEM IDENTIFICATION AND RESOLUTION PROGRAM INSPECTION
The licensee staff used the notification system appropriately to identify issues needing review for corrective actions. Daily issue review and prioritization meetings focused on safety and minimization of plant risk. Operators reviewed the risk worth of planned work activities. Operability determinations appeared adequate for the reviewed issues. Identified issues were being reviewed for apparent and root causes. Root cause evaluations were conducted to an appropriate depth and provided associated corrective actions. Corrective actions for identified issues were effective, commensurate with the safety significance of the issues, and sensitive to the necessity for reliable equipment performance. The extent of condition and generic applicability for significant conditions adverse to quality were properly considered. The size of the corrective action backlog and timeliness of corrective action completion, with respect to safety significance, was formally tracked and managed. The licensee had taken actions commensurate with the importance of service water system issues; however, detritus and silt continued to challenge the operators and plant equipment. Self-assessments and audits were self-critical and provided appropriate feedback, including notifications and recommendations.
Inspection Report# : 2001004*(pdf)*

Last modified : March 28, 2002