

Salem 2

1Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2004

Identified By: Self Disclosing

Item Type: FIN Finding

SALEM UNIT 2 AUTOMATIC REACTOR TRIP ON SEPTEMBER 9, 2004

A self-revealing finding was identified when the Salem Unit 2 reactor automatically tripped on September 9, 2004, in response to a generator protection trip. PSEG failed to incorporate vendor recommended daily and weekly inspections of the Salem Unit 2 exciter brushes. A brush failure resulted in a generator protection trip. The finding was not a violation of NRC requirements, in that the performance deficiency occurred on a non-safety related system.

Traditional enforcement does not apply because the issue did not have any actual safety consequences or potential for impacting the NRC's regulatory function and was not the result of any willful violation of NRC requirements. The finding is greater than minor because it affected the equipment performance attribute and impacted the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors conducted a Phase 1 SDP screening and determined the finding to be of very low safety significance (Green). The finding screened to Green because the issue did not involve a loss-of-coolant accident or external event initiator, and mitigation equipment was also not involved.

Inspection Report# : [2004005\(pdf\)](#)

Significance: G Sep 30, 2004

Identified By: Self Disclosing

Item Type: FIN Finding

SALEM UNIT 2 MANUAL REACTOR TRIP ON JULY 15, 2004

A self-revealing finding was made apparent when Salem Unit 2 was manually tripped on July 15, 2004, by control room operators for a 23 steam generator feedwater regulating valve malfunction. The reactor trip was preceded by a low steam generator water level automatic reactor trip on July 13, 2004, for the same equipment malfunction. Corrective actions prior to the July 15, 2004, trip were not adequate to prevent recurrence of this problem. The finding was not a violation of NRC requirements, in that the performance deficiencies occurred on non-safety related systems.

Traditional enforcement does not apply because the issue did not have any actual safety consequences or potential for impacting the NRC's regulatory function and was not the result of any willful violation of NRC requirements. The finding is greater than minor because it affected the equipment reliability attribute and had an impact on the objective of the Initiating Events and Mitigating Systems Cornerstones. In accordance with Inspection Manual 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors conducted a Phase 2 SDP evaluation of the significance of the performance deficiency and determined the finding was of very low safety significance.

Inspection Report# : [2004004\(pdf\)](#)

Significance: G Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

21 CONTROL ROOM VENTILATION CHILLER REPETITIVE FAILURE

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for failure to implement corrective actions and preclude service water flow control valve 21SW102 failure. In December 2003, PSEG developed corrective actions to improve the reliability of the SW102 valves. The corrective actions were not effectively implemented and did not prevent the recurring failure of 21SW102 on May 17, 2004.

This finding was more than minor because it was associated with the equipment performance attribute, and it affected the initiating event cornerstone objective. In accordance with Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors conducted a Phase 2 SDP evaluation of the significance of the performance deficiency and determined the finding was of very low safety significance (Green). In this evaluation, the inspectors assumed an exposure period of less than three days, the likelihood of a loss of control room ventilation event was increased by one order of magnitude, all mitigating equipment for a loss of control room ventilation event was unaffected by the finding, and operator recovery actions were feasible.

Inspection Report# : [2004003\(pdf\)](#)

Mitigating Systems

Significance:  Mar 18, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

UNTIMELY PROBLEM RESOLUTION FOR REPEAT FAILURES OF 125VDC BATTERY CHARGERS

The team identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for ineffective and untimely corrective action associated with the 1C1 125VDC battery charger. NRC inspection report 05000272, 05000311/2004004, documented several previous battery charger failures, but timely corrective actions were not implemented to eliminate the identified defective condition for all battery chargers of identical design and like vintage. Consequently, the failure of another battery charger occurred on November 16, 2004.

This finding was more than minor because it was associated with the equipment performance attribute, and it affected the Mitigating Systems cornerstone objective to ensure the capability and reliability of systems that respond to initiating events. The finding was of very low safety significance based upon a Phase 1 SDP, because the finding was not a design deficiency, it did not result in an actual loss of safety function, and it did not screen as potentially risk significant for externally initiating events (seismic, flooding, or severe weather). The performance deficiency had a problem identification and resolution (corrective actions) cross cutting aspect.

Inspection Report# : [2005007\(pdf\)](#)

Significance:  Mar 18, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

DEFICIENT CONTROL AREA CHILLER CONTROLS

The team identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for failure to implement timely and effective corrective actions following repetitive failures of the control area chillers due to a deficient temperature control system.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone. This finding affected the cornerstone objective, in that it reduced the availability and reliability of a system that responds to initiating events. The finding was determined to be of very low safety significance (Green) based upon a SDP Phase 1 analysis, because it was not a design deficiency, did not result in an actual loss of safety function, and did not screen as potentially risk significant due to external initiating events (seismic, flooding, or severe weather). The performance deficiency had a problem identification and resolution (corrective actions) cross cutting aspect.

Inspection Report# : [2005007\(pdf\)](#)

Significance:  Dec 31, 2004

Identified By: NRC

Item Type: FIN Finding

REPEAT UNAVAILABILITY OF THE GAS TURBINE DUE TO CONTROL SYSTEM FAULTS

The inspectors identified a failure to implement effective corrective actions following repetitive failures of the gas turbine control system. The finding was not a violation of NRC requirements because it pertained to non-safety related equipment.

Traditional enforcement does not apply because the issue did not have any actual safety consequences or potential for impacting the NRC's regulatory function and was not the result of any willful violation of NRC requirements. The finding was more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone. This finding affected the mitigating cornerstone objective, in that, it reduced the availability and reliability of a system that responds to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance based upon a SDP Phase 3 analysis.

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

TRASH RACK BIOFOULING CAUSES FAILURE OF NUMBER 26 SERVICE WATER PUMP

A self-revealing finding was identified when the 26 service water pump was rendered inoperable due to biological fouling of the suction trash rack on September 22, 2004. A large amount of biological growth had previously been identified on the trash rack during an inspection on August 2, 2004; however, PSEG did not clean the trash rack following the inspection. The finding was determined to be a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action."

Traditional enforcement does not apply because the issue did not have any actual safety consequence or potential for impacting the NRC's regulatory function and was not the result of any willful violations of NRC requirements. The finding was more than minor because it was

associated with the equipment availability attribute of the mitigating systems cornerstone objective to maintain the availability of systems that respond to initiating events to prevent undesirable consequences. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors conducted a Phase 1 SDP screening and determined that a Phase 2 evaluation was required because the performance deficiency degraded both the initiating event and mitigating systems cornerstones. However, the inspectors were unable to evaluate the finding using Phase 2, because the Risk-Informed Inspection Notebook for Salem Generating Station did not evaluate loss of service water initiating events. The Region I Senior Reactor Analyst (SRA) conducted a Phase 3 analysis which determined that the finding was of very low safety significance (Green).

Inspection Report# : [2004005\(pdf\)](#)

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Significance: Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

INCORRECT TEMPORARY MODIFICATION INSTALLATION

The inspectors identified a failure to properly translate temporary modification (TM) instructions into the associated work order. As a result, incorrect sealant was applied around seven floor drain covers in Salem Unit 1 and Unit 2 auxiliary buildings. The covers protected safety-related systems, structures, and components in mild areas of the auxiliary building from being exposed to the harsh environment (higher temperature and humidity) associated with a main steam line break. The finding was determined to be a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings."

Traditional enforcement does not apply because the issue did not have any actual safety consequence or potential for impacting the NRC's regulatory function and was not the result of any willful violations of NRC requirements. The finding was more than minor because it was associated with the design control attribute of the mitigating systems cornerstone and affected the objective to maintain the reliability and availability of systems that respond to initiating events to prevent undesirable consequences in the auxiliary building from being exposed to a harsh environment. In accordance with Inspection Manual 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors conducted a Phase 1 SDP Screening and determined the finding to be of very low safety significance (Green). The finding screened to Green because the issue was a qualification deficiency confirmed not to result in a loss of function.

Inspection Report# : [2004005\(pdf\)](#)

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Significance: Jun 24, 2004

Identified By: NRC

Item Type: FIN Finding

FAILURE TO CONDUCT SALEM SIMULATOR TESTING IN ACCORDANCE WITH ANSI/ANS 3.5-1993

The inspectors identified that simulator performance testing on the Salem simulator did not meet the standards as specified in ANSI/ANS 3.5-1993 in that: (1) "best estimate" data for the simulator testing was not used; (2) some (4 of the 11 required) annual simulator transient tests were not performed and; (3) simulator test documentation did not include an evaluation and validation of test results.

This finding is more than minor because it affects the human performance (human error) attribute of the mitigating systems cornerstone. Improperly conducted simulator testing brings simulator fidelity into question. The finding is of very low safety significance (Green) because the discrepancy did not have an adverse impact on operator actions such that safety related equipment was made inoperable during normal operations or in response to a plant transient.

Inspection Report# : [2004007\(pdf\)](#)

Barrier Integrity

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Significance: Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

REPETITIVE 25 CONTAINMENT FAN COIL UNIT FAILURE

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for failure to implement corrective actions and preclude service water flow control valve 25SW223 failure and inoperability of its associated containment fan coil unit (CFCU). In October 2000, PSEG assigned corrective actions to improve the reliability of control air to all Unit 1 and Unit 2 SW223 valves in order to address a know design deficiency. The corrective actions were not implemented on the 25SW223 valve prior to its failure on April 18, 2004, due to the same cause.

This finding was more than minor because it was associated with the structures, systems, or component performance attribute and it affected the barrier integrity cornerstone objective. The inspectors determined that the finding was of very low safety significance using Inspection Manual Chapter 0609, Appendix H, "Containment Integrity Significance Determination Process," because the CFCUs are not important to large early release frequency, in that, the Salem units have large dry containments and the CFCUs only impact late containment failure and source terms.

Inspection Report# : [2004003\(pdf\)](#)

G**Significance:** Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE TROUBLESHOOTING PROCEDURES CAUSE AN INADVERTENT SI SIGNAL

Green self-revealing non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was made apparent for failure to provide maintenance instructions appropriate to the circumstances for troubleshooting activities on the solid state protection system which led to an invalid safety injection signal actuation and caused the control room emergency air conditioning system to be unable to meet General Design Criteria 19 for approximately 2 hours.

This finding was greater than minor because it resulted in the Unit 2 control room emergency air conditioning system being aligned such that it did not comply with its design basis for post loss of coolant accident mitigation. The inspectors determined that the finding was of very low safety significance (Green) using the Phase 1 SDP because the finding only represented a degradation of the radiological barrier function provided for the control room.

Inspection Report# : [2004003\(pdf\)](#)**G****Significance:** Jun 30, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE OF 11 TRAVELING WATER SCREEN DUE TO ICE BUILDUP

A self-revealing non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was made apparent for failure to identify and correct a condition that rendered the 11 service water traveling water screen (TWS) unavailable.

This finding was more than minor because it was associated with the equipment performance attribute, and it affected the Initiating Event and Mitigating System Cornerstone objectives. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the Region I Senior Reactor Analyst (SRA) conducted a Phase 3 SDP analysis of the significance of the performance deficiency and determined the finding was of very low safety significance (Green). In this analysis, the SRA assumed that the 11 TWS was out-of-service for 68 hours and that the loss of service water (LOSW) initiating event frequency increased during this time because of lost redundancy in the service water trains as a result of the performance deficiency. The SRA determined that the increase in core damage frequency due to internally initiated events was in the low E-8 range.

Inspection Report# : [2004003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : June 17, 2005