

# Peach Bottom 3

## 1Q/2008 Plant Inspection Findings

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### Initiating Events

**Significance:**  Jun 30, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

#### **Inadequate Implementation of Work Order Instructions Caused the Installation of an Incorrect Size Breaker and Resulted in a Fire in the '4T4' 480 Volt Load Center**

A self-revealing finding was identified for inadequate implementation of work order (WO) instructions to verify the correct breaker frame size during the overhaul of a compatible spare breaker for installation into the '4T4' 480 volt load center. This condition resulted in a poor electrical connection between the primary disconnect fingers and the switchgear bus stabs for one breaker in the '4T4' load center that ultimately resulted in a fire that led to a plant transient and declaration of an Unusual Event (UE).

This finding is greater than minor because it affected the human performance attribute of the Initiating Event Cornerstone, in that, an incorrect frame size breaker was installed into a cubicle for which it was not sized. This mismatch caused an electrical fault that led to a fire and a plant transient that upset plant stability. This finding was of very low safety significance (Green) because it did not increase both the likelihood of a reactor scram and that mitigation equipment or functions would not be available. The cause of this finding had a cross-cutting aspect in the area of human performance (work practices component) because maintenance technicians did not follow WO instructions to specifically verify the frame size of a breaker during its overhaul (IMC 0305 aspect H.4(b)). (Section 4OA3.1)

Inspection Report# : [2007003](#) (*pdf*)

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### Mitigating Systems

**Significance:**  Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Include Reactor Building Drain System Into the Scope of the Maintenance Rule Program**

A Green non-cited violation (NCV) of 10 CFR 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified for PBAPS's failure to include the reactor building equipment and floor drain plugs in the scope of the Maintenance Rule (MR) program and, therefore, the station did not recognize that appropriate preventative maintenance was not being performed. PBAPS entered this issue into the corrective action program and took action to assess the scoping of the reactor building floor and equipment drain systems into the preventive maintenance program.

The inspectors determined that this finding was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of protection against external factors, and impacted the cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that this finding is of very low safety significance because the condition was not a design or qualification deficiency confirmed not to result in a loss of operability, did not represent a loss of system safety function, did not represent an actual loss of safety function of a single train for greater than its TS allowed outage time, did not represent an actual loss of one or more risk-significant non-TS trains of equipment for greater than 24 hours, and did not screen as potentially risk-significant due to seismic, flooding, or severe weather. The inspectors also determined that this finding had a cross-cutting aspect in the area of problem identification and resolution (PI&R) because the licensee's procedure did not appropriately contain lessons learned from a similar event that had occurred in February 2007 (IMC 0305, P.2(b)).

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**Significance:** Jun 30, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **Missed Procedure Step Resulted in Unplanned Overloading of the E-3 EDG**

A self-revealing NCV of Technical Specification (TS) 5.4.1, was identified when operators inadequately implemented a surveillance procedure by missing a procedure step. The missed step placed the E-3 emergency diesel generator (EDG) in the isochronous mode of operation while it was synchronized to off-site power and resulted in an unexpected over-loading of the E-3 EDG.

This finding is more than minor because it was associated with the human performance attribute of the Mitigating Systems Cornerstone, and impacted the cornerstone objective of ensuring the availability of the E-3 EDG to respond to initiating events. This finding is of very low safety significance (Green) because all other EDGs remained operable and the actual loss of safety function of the E-3 EDG was less than the TS allowed outage time of seven days. This finding had a cross-cutting aspect in the area of human performance (work practices component) because PBAPS personnel did not follow procedure steps when transferring the E-3 EDG to the isochronous load control mode with the E-3 EDG synchronized to the off-site power source (IMC 0305 aspect H.4(b)). (Section 4OA3.2)

Inspection Report# : [2007003](#) (pdf)

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**Significance:** Jun 30, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **Procedural Compliance Issues Result in Damage to the Diesel Driven Fire Pump**

A self-revealing NCV of TS 5.4.1, was identified when operators manipulated a diesel-driven fire pump (DDFP) cooling water valve outside of procedure guidance. The improper manipulation led to misalignment of the DDFP cooling water that subsequently damaged the engine during operations without cooling water.

The failure to use a procedure for cleaning and restoring the DDFP cooling water strainer was a more than minor finding because it was associated with the degradation of a fire protection feature, in that, the DDFP was rendered inoperable by damage to the engine. Using the Fire Protection SDP, the finding was determined to be of very low safety significance due to the motor-driven fire pump remaining operable during the five days the DDFP was inoperable, and the small number of fire scenarios which would impact the power supply to the motor-driven fire pump. This finding had a cross-cutting aspect in the area of human performance (resources component) because procedure ST-O-37D-340-2 did not provide complete and accurate instructions for cleaning the DDFP cooling water strainer (IMC 0305 aspect H.2(c)). (Section 4OA3.3)

Inspection Report# : [2007003](#) (pdf)

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**Significance:** May 18, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Correct a 2006 NRC-Identified NCV in a Timely Manner - Quarterly Surveillance Test with Non-Conservative Acceptance Criteria for the HPCI Pump**

The NRC identified a Green NCV of 10CFR50, Appendix B, Criterion XVI, "Corrective Actions," related to the failure to correct the March 2006 deficiency identified in NCV 05000277,278/2006009-01, related to less than adequate acceptance criteria in a quarterly surveillance test procedure for the HPCI pumps. The team identified that Exelon had not revised the procedure and had continued to conduct the surveillance test, thirteen times since the issue was discovered by the NRC. Exelon performed an evaluation of the recent HPCI pump surveillance test results and concluded that the pumps currently met the design basis requirements, and had remained operable.

The performance deficiency has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because Exelon failed to take prompt corrective actions to address a safety issue in a timely manner,

The finding is more than minor because it affects the procedure quality attribute associated with the Mitigating Systems Cornerstone objective to ensure the capability of HPCI, a mitigating system. The finding is of very low safety significance because the finding was not a design or qualification deficiency, did not represent a loss of system safety function, and was not risk significant due to external initiating events. (Section 40A2.a(3)(a))

Inspection Report# : [2007006 \(pdf\)](#)

**Significance:**  Jun 08, 2000

Identified By: NRC

Item Type: AV Apparent Violation

**Assoc Circuit - Reliance on signal spurious assumption of one per system per fire.**

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 \(pdf\)](#)

Inspection Report# : [2007002 \(pdf\)](#)

**Significance:** N/A Jun 08, 2000

Identified By: NRC

Item Type: AV Apparent Violation

**Assoc Circuit - Mechanical Damage from Fire Induced Cable Faults not evaluated.**

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 \(pdf\)](#)

Inspection Report# : [2007002 \(pdf\)](#)

# Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

Last modified : June 05, 2008