

# Salem 2

## 4Q/2010 Plant Inspection Findings

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### Initiating Events

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: FIN Finding

#### **21 Steam Generator Feed Pump Trip**

A self-revealing finding of very low safety significance was identified on January 21, 2010, because a control system short circuit caused the 21 steam generator feed pump (SGFP) to trip. This caused a turbine runback and ultimately an automatic Unit 2 reactor trip due to low water level in one of four steam generators (SGs). The short circuit occurred because technicians did not use the correct procedure to repair degraded insulation on the barrel of a connector lug that was identified in the 21 SGFP control system in November 2009. PSEG repaired the short circuit prior to restart of Unit 2 on January 23, 2010. The issue was entered into the corrective action program as notification 20448229. PSEG's immediate corrective actions for this issue included repairing the degraded insulation, fixing lug alignment, and performing extent of condition inspections on the other Unit 2 SGFP panels for degraded insulation. No other deficiencies were identified.

This performance deficiency is more than minor because it is associated with the human performance attribute of the Initiating Events cornerstone, and it adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. Specifically, not following PSEG procedure SC.DE-TS.ZZ-2039 on November 11, 2009, caused the 21 SGFP trip and subsequent automatic reactor trip due to low SG water level on January 21, 2010. The finding was evaluated under IMC 0609, Attachment 4. The inspectors determined that the finding is of very low safety significance because it does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. The inspectors determined that this finding has a cross-cutting aspect in the area of human performance because PSEG personnel did not follow procedure requirements while repairing plant equipment. Specifically, technicians applied electrical tape to the 21 SGFP pressure switch connector lug barrel on November 11, 2009, which did not meet PSEG procedure SC.DE-TS.ZZ-2039 requirements.

Inspection Report# : [2010003](#) (*pdf*)

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### Mitigating Systems

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### Barrier Integrity

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### 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 : March 03, 2011