

Salem 2

4Q/2012 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadvertent Injection of Auxiliary Feedwater into the 23 Steam Generator

A self-revealing NCV of Technical Specification (TS) 3.7.1.2.a, "Auxiliary Feedwater System," was identified because the 23 steam generator flow control valve from the 21 auxiliary feedwater (AFW) pump went open unexpectedly during the in-service test of the 21 AFW pump. Specifically, the air supply to the 23AF21 valve was found closed, resulting in the valve opening when the pump was started and the inability to close this valve from the control room using the valve flow controller.

The inspectors determined that the performance deficiency was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone, and it adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Using IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that the finding was of very low safety significance (Green) because the system maintained the ability to inject water into each of the steam generators. Senior reactor analyst review determined that the valve failure to close is not modeled in sequences which could lead to core damage. Prompt corrective actions included labeling and tagging the adjacent air supply regulator that was used to supply air for other instrumentation calibration and testing. Corrective actions planned include revisions to the Maintenance Alteration Process procedure to require that all alterations to positionable components are reviewed and approved by a licensed senior reactor operator, and a revision to the Control of Equipment and System Status procedure to prohibit the operation of unlabeled equipment in the power block. The inspectors determined that this finding has a cross-cutting aspect in the area of human performance, work practices, because PSEG did not adequately communicate human error prevention techniques, such as holding pre-job briefs and self and peer checking. Specifically, flagging and robust barriers were not used in a situation where multiple similar components existed within close proximity to each other, which resulted in the isolation of the air regulator valve for valve 23AF21, located next to an unmarked air regulator valve that had been utilized for testing of instrumentation.

Inspection Report# : [2012004](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

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