Peach Bottom 2
2Q/2013 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 30, 2012
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Preplanning and Performance of Maintenance/Modifications Resulted in Unavailability of RHR 'B' Loop.
The inspectors identified a Green, self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4.1, “Procedures.” The inspectors determined that PBAPS did not properly preplan and perform maintenance/modifications to the Unit 2 low pressure coolant injection (LPCI) swing bus ‘B’ motor control cabinet (MCC) while energized. Specifically, PBAPS did not appropriately consider the potential plant impact due to sensitive energized components within the MCC that could be activated and did not utilize sufficient physical barriers to prevent such activation. Consequently, on July 25, 2012, the ‘B’ loop of the residual heat removal (RHR) system was declared inoperable and unavailable after workers pulling an electrical cable into the Unit 2 energized LPCI swing bus ‘B’ MCC inadvertently contacted and actuated the LPCI inboard injection valve motor relay. The motor operated valve (MOV) relay actuation caused a potential over-thrust event and had the potential to impact the valve’s qualification and reliability. PBAPS conducted detailed examinations and diagnostic stroke testing on the MOV assembly and concluded that the design limits of the MOV assembly were not exceeded.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating System cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that this finding was of very low safety significance (Green) because it did not represent an actual loss of safety function of a single LPCI train for greater than its TS allowed outage time. The inspectors determined that this finding had a cross-cutting aspect in the area of Human Performance, work control, because PBAPS did not appropriately incorporate risk insights and job site conditions that could impact plant structures, systems, and components (SSCs) into its work activities. Specifically, PBAPS did not appropriately consider and reduce the potential for an over-thrust event on the ‘B’ loop LPCI inboard injection valve MO-2-10-25B when performing work in the LPCI swing bus ‘B’ MCC while it was energized. [H.3(a)] (Section 1R13)
Inspection Report# : 2012004 *(pdf)*

Barrier Integrity

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: FIN Finding
Inadequate Operability Determination in Response to Power Load Unbalance Device Failure
The inspectors identified a Green finding for PBAPS's failure to follow the operability determination (OD) process described in Procedure OP-AA-108-115, “Operability Determinations.” Specifically, on February 24, 2013, between 6:15 a.m. and 10:30 a.m., an immediate determination of operability was not made in a timely manner, and was not initially documented in accordance with the corrective action process (CAP), following discovery that Unit 2 was operating outside of the analyzed limits specified in the core operating limits report (COLR) with the power load unbalance (PLU) circuit out of service (OOS). Consequently, operators entered the Unit 2 minimum critical power ratio (MCPR) technical specification limiting condition for operation (TS LCO) 3.2.2, Condition A, after exceeding the two-hour required action completion time. The inspectors determined that the immediate determination of operability was not performed in a matter commensurate with the safety significance of the two-hour LCO required action completion time. The inspectors determined that this was not a violation of TSs because subsequent analysis by a third party vendor determined that MCPR thermal limits were satisfied between 85 percent and 100 percent reactor power with the PLU circuit OOS on Unit 2.

This finding is more than minor because it is associated with the design control attribute of the barrier integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance that the physical design barriers (fuel cladding) protect the public from radionuclide releases caused by events. Using IMC 0609, Attachment 4, “Phase 1 – Initial Screening and Characterization of Findings,” and IMC 0609, Appendix A, “The SDP for Findings At-Power,” the inspectors determined that this issue screened to Green, because it was associated only with the fuel cladding barrier. The inspectors determined that this finding had a cross-cutting aspect in the area of Human Performance, decision-making, because PBAPS did not use conservative assumptions in decision making and did not adopt a requirement to demonstrate that the proposed action was safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disprove the action [H.1(b)]. (Section 1R13)

Inspection Report# : 2013002 *(pdf)*

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

Significance: N/A May 24, 2013
Identified By: NRC
Item Type: FIN Finding
2013 Problem Identification and Resolution (PI&R) Inspection Summary
The inspectors concluded that Exelon was generally effective in identifying, evaluating, and resolving problems. Exelon personnel identified problems, entered them into the corrective action program at a low threshold, and in general, prioritized issues commensurate with their safety significance. Exelon appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Exelon implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

The inspectors concluded that Exelon adequately identified, reviewed, and applied relevant industry operating experience to Peach Bottom operations. In addition, based on those items selected for review, the inspectors determined that Exelon's self-assessments and audits were thorough.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues, nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

No findings were identified.

Inspection Report# : 2013008 *(pdf)*

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