

Salem 1

4Q/2007 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  May 01, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT STEP 3.6.2 OF THE COMPONENT FOULING PROCEDURE

The inspectors identified an NCV for failure to comply with 10 CFR 50, Appendix B, Criterion V, "Instruction, Procedures, and Drawings," when operators did not implement additional log readings for service water (SW) heat exchangers (HXs) as specified by plant procedures during extended periods of high river detritus from March through May of 2007. This required PSEG to take the 12 CC HX out of service for 45 hours to complete system flushes in May and June 2007 to restore full operability. The finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors conducted a Phase 1 SDP screening in accordance with IMC 0609 and determined that the finding is of very low safety significance.

The finding has a cross-cutting aspect in the area of human performance because PSEG personnel did not follow plant procedures (H.4.b). Specifically, operators did not implement additional log readings for SW HXs as specified by plant procedures during extended periods of high river detritus from March through May of 2007.

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

Significance:  Mar 31, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

15 SERVICE WATER PUMP UNAVAILABILITY

A self-revealing non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified because PSEG did not conduct maintenance in accordance with appropriate written procedures. Specifically, the pump packing was not adequately cooled during the PMT, damaging the 15 SWP.

The finding is more than minor because it impacted the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, incorrectly performed maintenance reduced the availability of the 15 SWP. In accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors conducted a Phase 1 screen and determined that this finding required a Phase 2 analysis because both the Initiating Event and Mitigating Systems Cornerstones were adversely impacted by the 15 SWP unavailability. Based upon the Risk-Informed Notebook for Salem Generating Station not containing a Loss of Service Water worksheet, the Senior Reactor Analyst (SRA) conducted a Phase 3 risk assessment and determined that the finding was of very low safety significance (Green).

The performance deficiency has a cross-cutting aspect in the area of human performance because PSEG did not effectively communicate human error prevention techniques. Maintenance technicians assigned to perform the post-maintenance test were unfamiliar with the task. The pre-job brief did not discuss in detail the application of external cooling water to the packing gland during packing break in. At the job site, maintenance technicians proceeded with the post-maintenance test in the face of uncertainty, resulting in equipment damage.

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

G**Significance:** Mar 23, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

12 CHILLER RENDERED UNAVAILABLE DUE TO INADEQUATE MAINTENANCE

A self-revealing non-cited violation of Technical Specification 6.8.1 was identified when improper maintenance caused the 12 control area chiller to trip and remain unavailable for approximately 70 hours on July 15, 2006. Maintenance was incorrectly performed on a chiller unloader device that caused the chiller to overcool the chilled water system resulting in a valid automatic freeze-protection trip of the refrigerant compressor. PSEG repaired the chiller, verified that the other five chiller units were correctly maintained, trained maintenance technicians on the error, and are currently reviewing the maintenance procedure for enhancement opportunities.

The performance deficiency was determined to be more than minor because it rendered the 12 chiller unavailable for use. The performance deficiency was determined to be of very low risk significance (Green) by a Phase 3 analysis by a regional Senior Risk Analyst. The performance deficiency had a cross-cutting aspect in the area of human performance because PSEG personnel did not follow applicable maintenance procedures when performing maintenance on the 12 control area chiller unloader device.

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

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

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.

Miscellaneous

Significance: N/A Mar 23, 2007

Identified By: NRC

Item Type: FIN Finding

SALEM BIENNIAL PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION

The inspectors concluded that the implementation of the corrective action program (CAP) at Salem was effective. Salem had a low threshold for identifying problems and entering them in the CAP. Once entered into the system, items were screened and prioritized in a timely manner using established criteria. Items entered into the CAP were

properly evaluated commensurate with their safety significance. Corrective actions were implemented in a timely manner. PSEG's audits and self-assessments were adequate, however, some self-assessment recommendations were not entered into the CAP. The inspectors observed that PSEG adequately identified, reviewed, and applied relevant industry operating experience through station programs. Based on interviews conducted during the inspection, workers at the site expressed freedom to enter safety concerns into the CAP.

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

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Significance: Mar 23, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

FITNESS-FOR-DUTY (FFD) COLLECTION PERSONNEL COLLECTING FFD SAMPLES FROM CO-WORKERS

The NRC identified a non-cited violation of 10 CFR 26, Appendix A, subpart B, 2.3 (1) when the inspectors observed PSEG's fitness-for-duty (FFD) collection technicians and security officers perform urine and breath collection on co-workers on March 21, 2007. PSEG implemented immediate corrective actions by stopping the practice of collection personnel performing urine and breath collections on other collection technicians, enhancing the station FFD procedures, and by conducting FFD testing of the affected individuals.

The performance deficiency was determined to be more than minor because, if left uncorrected, it would affect the integrity of the FFD program. The finding was determined to be of very low safety significance (Green) using the Physical Protection Significance Determination Process. The finding had a cross-cutting aspect in the area of Human Performance in that PSEG did not have FFD adequate procedures that ensured that the regulatory requirements prohibiting collectors from collecting samples from co-workers were followed.

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

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Significance: Mar 23, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

FITNESS-FOR-DUTY (FFD) COLLECTORS LEAVING FFD SPECIMENS UNATTENDED

The NRC identified a non-cited violation of 10 CFR 26, Appendix A, Subpart B, 2.4 (g) (20) when the inspectors observed PSEG's fitness-for-duty (FFD) collection technicians leaving split FFD urine specimens in unsealed aliquot tubes and sealed specimen containers in unattended work areas on March 21, 2007. The licensee implemented immediate corrective measures by capping and sealing FFD aliquot specimens, requiring that FFD donors witness the transfer of their FFD urine specimen to a laboratory technician through a chain-of-custody form, and by sampling an additional 25 percent of PSEG employees for a FFD test.

The performance deficiency was determined to be more than minor because, if left uncorrected, it could affect the integrity of the FFD program. The inspector determined that the finding was of very low safety significance (Green) using the Physical Protection Significance Determination Process. The finding had a cross-cutting aspect in the area of Human Performance in that PSEG failed to effectively communicate expectations regarding procedural compliance and personnel did not follow procedures.

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

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