July 27, 2001

Mr. Harold W. Keiser
Chief Nuclear Officer and President
PSEG Nuclear LLC - X04
P. O. Box 236
Hancocks Bridge, NJ 08038

SUBJECT: SALEM NUCLEAR GENERATING STATION - NRC INSPECTION REPORT 50-272/01-07, 50-311/01-07

Dear Mr. Keiser:

On June 30, 2001, the NRC completed an inspection of your Salem 1 & 2 reactor facilities. The enclosed report documents the inspection findings which were discussed on July 19, 2001, with Mr. Dave Garchow and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel. Specifically, this inspection involved six weeks of resident inspection and a region-based inspection of physical security.

No findings of significance were identified.

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Sincerely,

/RA J. Schoppy for/

Glenn W. Meyer, Chief
Projects Branch 3
Division of Reactor Projects

Enclosure: Inspection Report 50-272/01-07, 50-311/01-07
Attachment: Supplementary Information

Docket No. 50-272; 50-311
License No. DPR-70, DPR-75

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REGION I

Docket Nos:	50-272, 50-311
License Nos:	DPR-70, DPR-75
Report No:	50-272/01-07, 50-311/01-07
Licensee:	PSEG Nuclear LLC
Facility:	Salem Nuclear Generating Station, Units 1 & 2
Location:	P.O. Box 236 Hancocks Bridge, NJ 08038
Dates:	May 20 - June 30, 2001
Inspectors:	Raymond K. Lorson, Senior Resident Inspector F. Jeff Laughlin, Resident Inspector Stephen M. Pindale, Reactor Engineer Todd H. Fish, Operations Engineer Gregory C. Smith, Sr. Physical Security Inspector Paul R. Frechette, Physical Security Inspector
Approved By:	Glenn W. Meyer, Chief Projects Branch 3 Division of Reactor Projects

Summary of Findings

IR 05000272-01-07, IR 05000311-01-07, on 5/20 - 6/30/01, Public Service Electric Gas Nuclear LLC, Salem Units 1 and 2. Resident inspector report.

The inspection was conducted by resident inspectors, with support from region-based inspectors, and regional security specialists. This inspection identified no findings of significance. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html.

A. Inspector Identified Findings

No findings of significance were identified.

B. Licensee Identified Findings

No findings of significance were identified.

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Report Details

SUMMARY OF PLANT STATUS

Unit 1 began the period with the operators escalating power following refueling outage 14. On May 22 the unit automatically tripped from 100 percent power in response to a main turbine trip (Section OA3.1). The operators restarted the reactor on May 24, and returned the reactor to 100 percent power on May 28. The operators reduced reactor power to 30 percent on June 13 in response to the loss of the No. 1 station power transformer (Section OA3.2). The unit was returned to 100 percent power on June 14. On June 27 the full power rating of the plant was increased by 1.4 percent per design change package (DCP) 80010288.

Unit 2 began the period operating at approximately 100 percent power. On June 6 the full power rating of the plant was increased by 1.4 percent per DCP 80010288. The operators reduced reactor power to 80 percent on June 13 in response to the loss of the No. 1 station power transformer (Section OA3.2). The unit was returned to 100 percent power on June 14.

1. REACTOR SAFETY

Initiating Events, Mitigating Systems, and Barrier Integrity [Reactor - R]

R04 Equipment Alignment

a. Inspection Scope

On June 12 the inspectors performed a partial system walkdown of the component cooling water (CCW) system while the 13 CCW pump was removed from service for planned maintenance. On June 28 the inspectors also completed a partial walkdown of the auxiliary feed water (AFW) system during a planned outage of the 11 AFW pump. The inspectors verified that the redundant components were properly aligned to perform their intended safety function, protected by administrative controls, and in an acceptable material condition.

The inspectors also performed a complete walkdown of the Unit 1 control air system components located in the inner penetration and inner main steam penetration areas. The inspector compared the system configuration to the system valve line-up sheets, interviewed the system engineer and reviewed the material condition of the system. Additionally, the inspectors reviewed PSEG Nuclear's response to minor material deficiencies identified during the walkdown. Specifically, the inspectors noted that the system engineer planned to enter deficiencies involving the labeling of two valves, a broken valve handwheel, and a valve line-up sheet discrepancy into the corrective action program.

b. Findings

No findings of significance were identified.

R05 Fire Protection

a. Inspection Scope

The inspectors toured the following risk-significant plant areas to assess PSEG Nuclear's control of combustible materials and ignition sources, the material condition of fire detection and suppression equipment, and the operational status of fire barriers. They verified on a sampling basis that fire impairments were documented and that adequate compensatory measures were in place.

- Unit 1 and 2 turbine-driven AFW pump rooms
- Unit 1 and 2 emergency diesel generator (EDG) fuel oil storage tank rooms
- Unit 2 EDG rooms
- Unit 2 upper and lower electrical penetration rooms
- Unit 2 mechanical penetration room

b. Findings

No findings of significance were identified.

R11 Licensed Operator Requalification

a. Inspection Scope

The inspector observed a June 5, 2001, simulator training session for one crew during licensed operator training. The scenario involved a reactor coolant pump trip with a loss of coolant accident. The inspector assessed the scope and adequacy of the scenario, operator performance in mitigating the consequences of the simulated event, and the effectiveness of the training staff in identifying crew deficiencies. The inspector observed that the training staff properly identified and characterized crew weaknesses and noted some areas for training emphasis. He also discussed his observations with the training staff.

b. Findings

No findings of significance were identified.

R12 Maintenance Rule Implementation

The inspectors reviewed the list of systems in (a)(1) status and the trend status report that compares (a)(2) system performance against the associated performance criteria. Six systems were selected for a detailed review of the corrective action plans including: control air, radiation monitoring, service water, 115VAC, 125VDC, and 4KV. For these systems the inspectors reviewed the system health reports and corrective action plans, and interviewed the system performance engineers and maintenance rule engineer. Additionally, the inspectors reviewed the new preventive maintenance items developed and progress towards completion of the action plans to assess the effectiveness of PSEG Nuclear's corrective action plans.

The inspectors also reviewed twelve control air and electrical system problem notifications that had been classified as non-functional failures (NFF) to determine the adequacy of the classifications. The inspectors also reviewed notification 20056473 that documented an improper NFF determination in response to a failure of the 12 containment fan cooler unit (CFCU) to start in high speed. The determination was based on the fact that high speed operation of the fans was required to satisfy a system maintenance rule function.

b. Findings

No findings of significance were identified.

R13 Maintenance Risk Assessments and Emergent Work Control

.1 Unit 1 Refueling Water Storage Tank Leakage

a. Inspection Scope

On June 14 Salem operators declared the Unit 1 refueling water storage tank (RWST) inoperable due to a possible flaw on the emergency core cooling system (ECCS) suction line from the tank, and appropriately entered Technical Specification Action Statement (TSAS) 3.5.5. Radiation protection personnel had discovered moisture collecting on the inspection hole at the base of the metal reinforcing plate which supports the ECCS suction line where it exits the tank, indicating possible tank leakage seeping between the tank and the plate.

The inspectors walked down the RWST area to observe the amount of moisture, reviewed notifications 20069330 and 20069355 which documented the issue, and discussed the issue with operations and engineering management. They also observed control room activities during the period that Unit 1 was in TSAS 3.5.5 (4:10 - 7:53 p.m.) and reviewed PSEG Nuclear's operability determination as discussed in Section R15.

b. Findings

No findings of significance were identified in this area. (An unresolved item is discussed in Section R15).

.2 22 Containment Fan Cooler Unit Inoperable Due to Broken Flow Transmitter

a. Inspection Scope

The inspectors reviewed PSEG's response on June 16 to an emergent surveillance test issue involving the 22 CFCU. Operators declared the 22 CFCU inoperable, initiated notification 20069513 and subsequently restored the 22 CFCU to service. The inspectors reviewed notification 20069513, discussed the issue with operations and maintenance management, and reviewed the Unit 2 PSA risk evaluation form to verify that the risk for this emergent work item had been appropriately assessed.

b. Findings

No findings of significance were identified.

.3 Safety Injection System Check Valve Leakage

a. Inspection Scope

The inspectors reviewed PSEG Nuclear's response to suspected seat leakage through safety injection check valves 21-24SJ17 and 2SJ150. The leakage was identified by plant operators on June 16 during performance of a routine seat leakage test on the 2SJ12 and 2SJ13 motor operated valves per operations procedure, S2.OP-PT.SJ-0001, "2SJ12 and 2SJ13 Leakage Test." The inspectors reviewed PSEG Nuclear's initial follow-up activities to this event that included: formation of a transient assessment response plan (TARP) team, re-seating of the safety injection check valves, and re-performance of the S2.OP-PT.SJ-001 procedure to measure the leakage past 2SJ12 and 2SJ13 and also to measure the combined leakage through the 21-24SJ17 and 2SJ150 check valves.

b. Findings

No findings of significance were identified.

R14 Personnel Performance During Nonroutine Plant Evolutions

.1 Unit 1 Reactor Start-Up

a. Inspection Scope

The inspector observed the reactor start-up on May 24 following the Unit 1 trip that occurred on May 22. The inspector observed crew communications, command and control, and the monitoring of reactor power during the approach to criticality.

b. Findings

No findings of significance were identified.

.2 Unit 2 Turbine Building Acid Vapor Event

a. Inspection Scope

On June 18 Unit 2 personnel were overseeing a sulfuric acid delivery when a chemistry technician detected strong acid fumes in the vicinity of the acid tanks at the 88 foot elevation of the turbine building. The Unit 2 operations supervisor (OS) declared an Unusual Event (UE) at 2:10 p.m. based on emergency action level (EAL) 9.4.1b, an uncontrolled toxic gas release within the protected area which resulted in limiting access to the turbine building. The OS had previously received incomplete information as to the extent of this condition, but was aware that one individual had reportedly inhaled some fumes. Therefore, the OS made the UE declaration after receiving a report at approximately 2:00 p.m. that personnel had secured access to the 88 ft elevation of the turbine building.

The inspectors reviewed the narrative, operations supervisor, and site protection logs; the Emergency Classification Guide (ECG); the event documentation; and notifications 20069747(personnel injury), 20069748 (sulfuric acid fumes in the turbine building), and 20069916 (communication problems during the event) which documented issues associated with this event. They also walked down the sulfuric acid delivery area and the 88 ft elevation of the Unit 2 turbine building, and interviewed operations and site protection personnel.

b. Findings

No findings of significance were identified.

R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed Operability Determination 01-007 documented in order 70017741 concerning the Unit 1 RWST leakage issue discussed in Section R13.1. They also reviewed the operability follow-up assessment documented as engineering calculation 1SC-163, "Evaluation of RWST Nozzle Leakage," and Station Operations Review Committee (SORC) meeting minutes 01-051 from the June 15 SORC meeting which approved OD 01-007. Lastly, the inspectors discussed the RWST operability basis and ASME Code compliance at length with engineering and operations management. At the conclusion of the period the inspectors were still reviewing PSEG Nuclear's position that PSEG Nuclear's actions regarding the RWST condition met the ASME Code requirements. This issue will remain unresolved pending further review of the ASME requirements for this condition. **(URI 05000272/2001-007-01)**

b. Findings

No findings of significance were identified.

R19 Post Maintenance Testing

a. Inspection Scope

The inspectors reviewed the post maintenance testing (PMT) associated with DCP 80008573, 125 VDC breaker DCP, as it applied to the 11 residual heat removal (RHR) pump. The inspectors also reviewed work orders 30027198, 30027299, and 30027304 for additional planned maintenance completed on the 11 RHR pump during this pump outage. Additionally, they observed portions of the PMT, and verified that the test scope was adequate for the work performed and that the pump met the technical specification (TS) acceptance criteria.

The inspectors observed portions of PMT activities and reviewed PMT data for the June 6 test of the 2B EDG in accordance with procedure S2.OP-ST.DG-0002(Q), "Inservice Testing of the 2B Emergency Diesel Generator," the June 22 test of the 22 CFCU in accordance with procedure S2.OP-ST.SW-0010(Q), "Inservice Testing

Containment Fan Coil Unit (CFCU) Service Water Valves," and the June 28 test of the 11 AFW pump valves in accordance with procedure S1.OP-ST.AF-0004(Q), "Inservice Testing Auxiliary Feedwater Valves Modes 1-6." The inspectors verified that these components met the appropriate TS acceptance criteria and were capable of performing their intended safety function. Additionally, the inspectors reviewed the scope of the PMT performed following re-seating of the safety injection system check valves as discussed in Section R13.3.

b. Findings

No findings of significance were identified.

R22 Surveillance Testing

a. Inspection Scope

The inspectors observed portions of surveillance S1.OP-ST.SW-0016(Q), "Inservice Testing Service Water Accumulator Discharge Valves," and reviewed the test results to verify that the results were in compliance with the applicable TS acceptance criteria and equipment design bases.

b. Findings

No findings of significance were identified.

3. SAFEGUARDS

Physical Protection [PP]

PP1 Access Authorization

a. Inspection Scope

The inspectors performed the following activities to determine the effectiveness of the behavior observation portion of the personnel screening and fitness-for-duty programs as measured against the requirements of 10CFR26.22 and the Fitness-for-Duty Program documents.

On June 12 the inspectors interviewed five supervisors from the maintenance, radiation protection, chemistry and security organizations to examine their understanding of behavior observation responsibilities and their ability to recognize aberrant behavior traits. The inspectors also reviewed two Access Authorization/Fitness-for-Duty self-assessments, an audit, and event reports and loggable events for the four previous quarters. On June 12, 2001, the inspectors interviewed five individuals who perform escort duties to establish their knowledge level of those duties. Additionally, the inspectors reviewed behavior observation training procedures and records on June 11, 2001.

b. Findings

No findings of significance were identified.

PP2 Access Control

a. Inspection Scope

The following activities were performed during the period June 11-13, 2001, to verify that PSEG Nuclear had effective site access controls, and equipment in place designed to detect and prevent the introduction of contraband (firearms, explosives, incendiary devices) into the protected area as measured against 10CFR73.55(d) and the Physical Security Plan and Procedures.

Site access control activities were observed, including personnel and package processing through the search equipment during peak ingress periods on June 11, 12, and 13, 2001, and vehicle searches on June 11, 2001. On June 12, 2001, testing of all access control equipment; including metal detectors, explosive material detectors, and X-ray examination equipment, was observed. The Access Control event log, an audit, and three maintenance work requests were also reviewed.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES [OA]

OA1 Performance Indicator Verification

a. Inspection Scope

The inspector reviewed PSEG Nuclear's programs for gathering and submitting data for the Fitness-for-Duty, Personnel Screening, and Protected Area Security Equipment Performance Indicators. The review included the tracking and trending reports, personnel interviews and security event reports for the Performance Indicator data collected from the 1st quarter of 2000 through the 1st quarter of 2001.

b. Findings

No findings of significance were identified.

OA3 Event Follow-up

.1 Unit 1 Reactor Trip

a. Inspection Scope

The inspector reviewed the operator actions, plant response and follow-up actions in response to an automatic Unit 1 trip that occurred on May 22 following a main turbine trip. The main turbine trip was initiated by a main generator trip that occurred due to faulted electrical leads on the current transformer for the generator differential protection circuit. The inspector reviewed safety system performance and key plant process parameters following the trip (i.e reactor power level, plant pressure and temperature, and pressurizer and steam generator water levels) to confirm that plant conditions were stable. The inspector also reviewed the post-trip review to confirm that the planned corrective actions, which included replacement of the faulted leads, were appropriate to address the cause of the trip.

b. Findings

No findings of significance were identified.

.2 Loss of the No. 1 Station Power Transformer

a. Inspection Scope

Inspectors assessed the operators' responses following a loss of No. 1 station power transformer at 9:25 a.m. on June 13, 2001. Both Salem units were operating at 100 percent power at the time of the event. The apparent cause of the event was a faulty protective relay and resulted in both units losing one independent offsite power source and one train of operating circulating water pumps (11A, 12A, and 13A on Unit 1; 21B, 22B, and 23B on Unit 2). Operators on both units appropriately entered 72-hour TSAS 3.8.1.1a for the loss of one offsite power source. Unit 2 reduced power to 82 percent after the event, while Unit 1 reduced power to 30 percent. The effect was greater on Unit 1 since the 13B circulating water pump was out of service for scheduled maintenance at the time of the event.

Inspectors responded to the control room to observe plant response and operator actions. The units responded as designed. Operators also responded appropriately in accordance with abnormal procedures that addressed loss of offsite power and condenser vacuum, as well as turbine load reduction. Inspectors confirmed that operators entered the appropriate TSAS and that no emergency action levels were applicable. Operators returned both units to full power on June 14 following successful trouble-shooting and repair efforts.

b. Findings

No findings of significance were identified.

.3 (Closed) Special Report 05000311/2001-01-001: Inoperable Reactor Vessel Level Indicating System (RVLIS) - Unit 2. This report described a condition where both RVLIS channels became inoperable at Unit 2. PSEG Nuclear entered TS 3.3.3.7 which required that one RVLIS channel be restored to an operable condition within 7 days or submit a special report in accordance with TS 6.9.4. PSEG Nuclear subsequently determined and corrected the cause for the RVLIS problem. The inspector determined

that their actions were reasonable, complete, and consistent with TS requirements. This report did not involve a violation of NRC requirements and is closed.

.4 (Closed) LER 05000272/2001-003: As-found Value for Main Steam Safety Valve Lift Setpoint Exceeds Technical Specification Allowable Limits. The inspector reviewed the LER and noted that it was captured in the corrective action program. No findings of significance were identified. This LER is closed.

.5 (Closed) LER 05000272/2001-004: Core Alterations Performed While Boration Flow Path Was Inoperable. This LER described an event where PSEG Nuclear rendered the 1B EDG inoperable by removing the EDG room equipment hatch while the EDG was a necessary support system for the 11 charging pump. The 11 charging pump was being relied upon meet the TS 3.1.2.3 requirements to have a charging pump operable during core operations. The corrective actions included re-installation of the EDG room equipment hatch, review of the outage schedule, and planned corrective actions to ensure that future work activities would be properly sequenced. The inspector determined that PSEG Nuclear's actions were reasonable and complete. This LER was considered to involve a minor violation of NRC requirements and will not be subject to further enforcement action. The LER is closed.

.6 (Closed) LER 05000272/2001-005: Control Room Emergency Air Intake Dampers Inoperable During Spent Fuel Pool Moves. PSEG Nuclear reported that, on April 18, movement of spent fuel occurred while the control room emergency air conditioning system (CREACS) was available but not operable. Specifically, the 1B 125V battery, that provides emergency power to the Unit 1 CREACS dampers, was removed from service. The Unit 1 CREACS dampers were powered from the associated DC bus during the movements. TS 3.7.6.1 action requires that the CREACS system be operable during spent fuel movements. PSEG Nuclear's planned corrective actions appeared reasonable and included procedural and training enhancements. The inspector determined that this event was a violation of minor significance and not subject to formal enforcement action. This LER is closed.

OA6 Management Meetings

a. Exit Meeting Summary

On July 19, 2001, the inspectors presented their overall findings to members of PSEG Nuclear management led by Mr. Dave Garchow of Salem Operations. PSEG Nuclear management stated that none of the information reviewed by the inspectors was considered proprietary.

ATTACHMENT

SUPPLEMENTARY INFORMATION

a. Key Points of Contact

D. Boyle, Maintenance Rule Engineer
K. Davidson, Operations Manager
R. Fisher, Security, Access Authorization
D. Garchow, Vice President - Operations
G. Gibson, Manager, Security
M. Ivanick, Security
J. Johnson, Security
R. Ritzman, Licensing
T. Straub, Security
R. Villar, Licensing Engineer

b. List of Items Opened, Closed, and Discussed

Open

URI 05000272/2001-007-01:	ASME Code Compliance of a Refueling Water Storage Tank Leak. (Section R15)

Closed

Special Report 05000311/2001-01-001:	Inoperable Reactor Vessel Level Indicating System (RVLIS) - Unit 2. (Section OA3.3)
LER 05000272/2001-003:	As-found Value for Main Steam Safety Valve Lift Setpoint Exceeds Technical Specification Allowable Limits. (Section OA3.4)
LER 05000272/2001-004:	Core Alterations Performed While Boration Flow Path was inoperable. (Section OA3.5)
LER 05000272/2001-005:	Control Room Emergency Air Intake Dampers Inoperable During Spent Fuel Pool Moves. (Section OA3.6)

c. List of Documents Reviewed

In addition to the documents identified in the body of this report, the inspectors reviewed the following documents and records:

Plant Access Training - Fitness for duty General Worker, Escort and Supervisor Study Guide, July 20, 2000
QA Assessment 2001-0239, Fitness for Duty Program, May 21, 2001
QA Assessment 2001-0054, Alarm Stations and Communications, March 6, 2001
QA Assessment 2000-038, Security Lock and Key Control, March 31, 2000
QA Assessment 2000-0068, Corrective Action Program Administration, March 17, 2000
QA Assessment 2000-0083, Security Access Control, March 21, 2000
QA Assessment 2000-0114, Security Contingency Response, May 5, 2000
QA Assessment 2000-0440, Access Authorization, December 8, 2000
QA Assessment 2000-0305, Security Plans and Procedures, September 22, 2000
QA Assessment 2000-0193, Fitness For Duty Program, June 28, 2000
SH.ER-DG.ZZ-0001(Z), Preventable and Repeat Functional Failure Determination
SH.SE-DG.ZZ-0081(Z), Maintenance Rule (a)(1) Evaluations and Goal Monitoring
NC.NA-AP.ZZ-0016(Q), Monitoring the Effectiveness of Maintenance

d. List of Acronyms

AFW	Auxiliary Feed Water
CCW	Component Cooling Water
CFCU	Containment Fan Cooler Unit
CREACS	Control Room Emergency Air Conditioning System
DCP	Design Change Package
EAL	Emergency Action Level
ECCS	Emergency Core Cooling System
ECG	Emergency Classification Guide
EDG	Emergency Diesel Generator
LER	Licensee Event Report
NCV	Non-cited Violation
NFF	Non-functional Failure
NRC	Nuclear Regulatory Commission
OS	Operations Supervisor
PARS	Publicly Available Records
PMT	Post Maintenance Testing
PSA	Probabilistic Safety Assessment
PSEG	Public Service Electric Gas
RHR	Residual Heat Removal
RVLIS	Reactor Vessel Level Indicating System
RWST	Refueling Water Storage Tank
SORC	Station Operations Review Committee
TARP	Transient Assessment Response Plan
TS	Technical Specification
TSAS	Technical Specification Action Statement
UE	Unusual Event
URI	Unresolved Item