

SHAW, PITTMAN, POTTS & TROWBRIDGE

A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS

2300 N STREET, N.W.
WASHINGTON, D.C. 20037-1128
(202) 663-8000
FACSIMILE
(202) 663-8007

JOHN H. O'NEILL, JR., P.C.
(202) 663-8148

FOIA/PA REQUEST

Case No: 96-506
Date Rec'd: 12-3-96
Action Off: Reed
Related Case: 96-351

November 27, 1996

Director, Division of Freedom of
Information & Publications Services
Office of Administration
U.S. Nuclear Regulatory Commission
Two White Flint North Building
11545 Rockville Pike
Rockville, MD 20852

**Re: Second Freedom of Information Act Request Regarding the Salem
Generating Station, Docket Nos. 50-272 and 50-311**

Dear Sir:

This is a Freedom of Information Act request pursuant to 5 U.S.C. § 552(a)(3) and 10 C.F.R. § 9.23. We request that you make available to Shaw, Pittman, Potts & Trowbridge the documents responsive to the attached Request for Production of Documents. These documents are needed as soon as possible to support depositions in an accelerated legal action. In order to expedite production, we have narrowed our request to specific documentation of a specific agency action.

We agree to bear the cost of this request as per 10 C.F.R. §§ 9.23(b)(4), 9.33, 9.39, and 9.40, and we authorize you to respond to this request piecemeal as documents become available. Please contact me at (202)663-8148, or William Hollaway at (202)663-8294, at your convenience if you have any questions regarding this request.

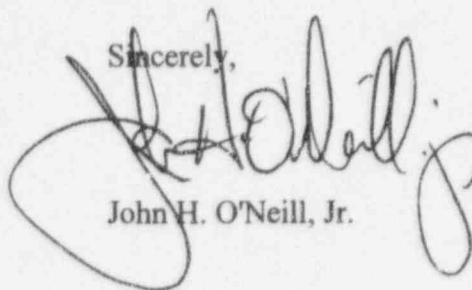
Please direct your response, pursuant to 10 C.F.R. § 9.27, to:

William R. Hollaway, Ph.D.
Shaw, Pittman, Potts & Trowbridge
2300 N Street, N.W.
Washington, D.C. 20037-1128
(202)663-8294
Fax: (202)663 007

Director, Division of Freedom of Information and Publications Services
November 27, 1996
Page 2

Thank you for your cooperation in this matter.

Sincerely,

A handwritten signature in dark ink, appearing to read "John H. O'Neill, Jr.", with a large, stylized loop at the end.

John H. O'Neill, Jr.

Attachment

REQUEST FOR PRODUCTION OF DOCUMENTS

I. DIRECTIONS AND INSTRUCTIONS

1. The term "NRC" means the United States Nuclear Regulatory Commission, all offices and/or branches thereof specifically including, but not limited to, headquarters in Rockville, Maryland and the Region I office in King of Prussia, Pennsylvania, and also includes all employees, consultants, agents, and representatives to the maximum extent permitted by 10 C.F.R. § 9.3, unless otherwise indicated by the request.
2. The term "Salem" means one or both units of the Salem Generating Station located in New Jersey and operated by the Public Service Electric and Gas Company.
3. The term "Hope Creek" means the Hope Creek Generating Station located in New Jersey and operated by the Public Service Electric and Gas Company.
4. The term "PSE&G" refers to the operator of Salem and Hope Creek, Public Service Electric and Gas Company.
5. The term "Senior Management Meeting" refers to the semi-annual meetings held by the NRC staff to review licensees' performance and to make decisions on which facilities to place on the "Watch List" and which facilities to issue a "Trending Letter."
6. The term "Trending Letter" means a letter issued by the NRC staff advising a specific licensee of adverse performance trends at a specific facility, pursuant to a decision made by the NRC Staff at a Senior Management Meeting.

II. DOCUMENTS REQUESTED

All documents relating to Salem and Hope Creek considered by the NRC Staff during, and created as a result of, the January 17-18, 1996 NRC Staff's Senior Management Meeting that led to the NRC Staff's decision to issue a Trending Letter to PSE&G for Hope Creek that also discusses Salem. The Trending Letter was issued on January 29, 1996.

Certain of these documents should be included in a meeting summary attached to a memo on results of the NRC Staff's Senior Management Meeting sent from Mr. James Taylor, EDO, to the Commissioners about two weeks after the meeting, at about the time the NRC Staff briefs the Commissioners in a public meeting.

III. DISCUSSION

The decision to send a Trending Letter to PSE&G regarding Hope Creek and Salem (particularly in light of the fact that the Salem units were shutdown and restart was subject to a Confirmatory Action Letter) represented a final agency decision appropriate for public disclosure under FOIA.

FOIA/PA REQUEST PROCESSING INSTRUCTIONS

1. Does your office have any agency records subject to this request? If yes, will significant search time and duplication be required? NOTE: If estimated search or review time exceeds one hour or duplication exceeds 250 pages, do not begin search until first talking to the FOIA Branch contact.
2. Do you anticipate any significant problems in processing this request and responding in the allotted time? If so, inform the FOIA Branch contact immediately.
3. Is there any other office not listed which might have records subject to this request? If so, inform the FOIA Branch contact immediately.

FOIA SEARCH INSTRUCTIONS:

1. Scope of Search: As a general rule, a search is adequate when all files are searched where individuals familiar with the subject matter of the request believe it is "reasonable" to expect to locate records responsive to the request by "reasonable" means of searching. The staff does not have to look into every conceivable file for records subject to a request. However all files must be searched, to include electronic files on personal computers (e.g., e-mail, word perfect, etc.), when it is likely that those files may contain records subject to the request.
2. Agency Records:
 - a. A request applies only to records in existence on the date the request is received by NRC. "In existence" includes records in a computer data file. Records created after a request is received by NRC may be made available as a matter of discretion by the staff, i.e., if the additional records are necessary to provide a complete picture of a situation or to avoid possible ambiguity.
 - b. If the requested information does not exist in record or computer format at the time a request is received, there is no obligation under the FOIA to create a record in order to be responsive to the request. However, if the information is retrievable by use of an existing computer program or by minor program modifications or simple computer instructions, the subject information should be provided.
 - c. If records have been destroyed prior to the receipt of the request, there is no obligation under the FOIA to tell the requester what was destroyed, when it was destroyed or why it was destroyed. Note, however, that no records may be destroyed after a request is received. E-mail records that have been deleted may still be retrievable and IRM should be contacted if a request specifically asks for e-mail records.

3. Submittal of Records to FOIA Branch:

- a. A careful review should be undertaken to (1) identify any material that should be withheld specifically as classified, safeguards, or proprietary information; and (2) identify all records from, or transmitted to, one or more commissioners, or which contain substantive excerpts from records received from, or transmitted to, the Commissioners.
- b. Group records on separate lists as follows:
 - Records already in the PDR.
 - Records being released in their entirety.
 - Records being released in part with exemptions noted.
 - Records withheld in their entirety with exemptions noted.
 - Records to be referred to another NRC office, other Federal agencies or to a business (e.g. licensee) that submitted the record.
- c. Inform the FOIA/LPDR Branch whenever requested records involve a subject for which litigation is either ongoing or is probable to ensure coordination with OGC and the Department of Justice.
- d. Harm statements must be supplied when Exemptions 2, 4 and 5 are claimed. Harm statements are not necessary for other exemptions unless the reason for withholding the information is not obvious. Obvious reasons would be home addresses, social security numbers, ongoing enforcement action, etc. Harm statements do not need to be elaborate or lengthy, but must provide enough information in order for FOIA Branch and OGC to understand the harm involved.

4. Reporting Search and Review Time and Duplication: A Staff Resources Report Form (NRC-496) is to be completed for all processing time. Your response memo and Appendices should be e-mailed to the assigned FOIA Caseworker.

If you have any questions, please telephone the FOIA/LPDR Branch Caseworker immediately.

REPORT OF STAFF RESOURCES FOR
PROCESSING FOIA REQUESTS

FOIA - 96-506

OFFICE EDC

REQUIRED ACTION

☒ SEARCH AND REVIEW
☐ REVIEW
☐ SEARCH

SEARCH -

All time spent by any staff member looking for material subject to a request, including time spent in page-by-page or line-by-line identification of material within records. Staff should not engage in search when duplicating the entire record is more efficient and less expensive for both the staff and the requester.

REVIEW -

All time spent by any technical, administrative and legal staff member examining records requested for a commercial use to determine whether information may be withheld and processing (e.g., bracketing; excising) the records for release.

COMPUTER -

When a computer search is required and a printout or a disk or tape copy of a computer file is produced, report time spent by the computer operator under "CLERICAL RESOURCES" regardless of whether or not the operator is a clerical or professional employee. If NRC is providing a disk or tape, report the Central Processing Unit (CPU) processing costs and the cost of the disk or tape under "COMPUTER COSTS."

Report ALL time spent (Show exact time in hours and minutes).

CLERICAL RESOURCES

NAME	SEARCH		REVIEW		TOTAL	
	HOURS	MINUTES	HOURS	MINUTES	HOURS	MINUTES

PROFESSIONAL/MANAGERIAL RESOURCES

NAME	SEARCH		REVIEW		TOTAL	
	HOURS	MINUTES	HOURS	MINUTES	HOURS	MINUTES

SES/COMMISSIONER RESOURCES

NAME	SEARCH		REVIEW		TOTAL	
	HOURS	MINUTES	HOURS	MINUTES	HOURS	MINUTES

COMPUTER COSTS

CPU PROCESSING COST	COST OF DISK	COST OF TAPE	TOTAL
\$	\$	\$	\$

SIGNATURE/FOIA COORDINATOR

DATE

Richardson

SAMPLE PPR SUMMARY

PRE-DECISIONAL SEMIANNUAL PLANT PERFORMANCE ASSESSMENT (PLANT NAME)

Assessment Period: Month/Year to Month/Year

SALP Period: Mn/Day/Yr Through Mn/Day/Yr (list the current SALP period unless near the beginning of SALP period)

Pervious SALP Rating: OPS _____
MAINT _____
ENG _____
PS _____

I. Performance Overview

This section should discuss the overall performance of the plant during the past six months. Include the "big picture" assessment that was developed during the PPR in this section. Problem areas that occurred in multiple SALP functional areas should also be discussed. Conclusions reached in the PPR on SAQV which do not fit well in a particular functional area discussion should be included in this section. The format for this section should include a brief narrative write-up on the general PPR assessment conclusions and the plant's operating history for the past six months.

II. Functional Area Assessments

There should be a section for each SALP functional area. Each section should use the same format. As noted earlier if sufficient data is not available to draw new conclusions on performance for a particular area then this should be noted and no new assessment will be provided.

The write-up for each functional area should focus on the changes and trends in licensee performance and avoid an excessive amount of details. The rationale for performing future inspections should be clearly stated.

All

Use the following format for each section:

- A. Provide a general statement on performance trends for that functional area and inspection effort recommendations (ie. increased, continuation of previous developed inspection plan, or decreased inspection activities).
- B. Briefly describe each assessment item and conclusion(s) reach in the PPR. Examples of the objective information that were used as the basis for the assessment should follow the assessment description and be in bullet format. Since most of the examples will be taken from the Plant Issues List, the listing of items in this section should only include a brief description that allows recognition of the example. If additional information is needed, the Plant Issues List can be reviewed. As an option the item numbers in the Plant Issues List which are used as the examples could be referenced in lieu of the brief description.
- C. Based on the results of the assessment, list the recommended inspections activities for the next six months and describe the rational for proposing these inspections. Also, discuss any deviations from the previously planned inspection effort and why the deviations were necessary. Determine if the basis for planning the inspection is still valid and if the inspection activity should be rescheduled.

At the end of this attachment is a sample write-up for the operations functional area section.

III. Future Inspection Activities

Once the inspection initiatives from each functional area have been factored into the regions overall inspection plan, each individual plant inspection plan can be formulated. Include the inspection plan in this section of the PPR package.

IV Attachments

1. Plant Issues List (Included as Attachemnt IV to this guidance)

Note that the examples listed on the attached Plant Issues List are provided for information. Each region should provide specific guidance on development of the Plant Issues List.

Include other attachments as determined by the region

"SAMPLE WRITE-UP FOR OPERATIONS FUNCTIONAL AREA"

II. Functional Area Assessments

1. Operations

- A. An overall decline in performance was noted in the area of operations. Additional personnel errors by operators was the main contributor to the decline. Increased inspection effort is recommended.
- B. Recent examples of operator personnel errors represent a continuing trend that was noted during the previous six month review period. Based on the most recent example occurring after the licensee's corrective actions were completed these efforts have not been fully successful.

- An operator failed to fully close a RHR vent valve following a pump surveillance test.
- The control switch for the inservice main feedwater pump was incorrectly selected and the pump was tripped during the August startup.
- Failure to ensure required radiation monitor was operable while pressurizing the containment to maintain pressure within the TS pressure limits.

Operators continued to perform well during plant events and transients.

- During the main feedwater pump/reactor trip the operators quickly recognized the malfunctioning AFW flow control valve and took action to prevent overfilling a S/G.
- The operators responded well to the partial loss of annunciator during a lightening storm.

Operators do not appear to be performing through plant tours. The minimum procedural requirements are being satisfied however a questioning attitude and an observant behavior has not been demonstrated.

- The leaking RHR vent valve was not discovered for two days. During this time period three shift tours of the RHR heat exchanger room were performed.
- The licensee did not recognize the poor housekeeping condition of the cable spreading room until it was identified by the resident inspectors.

- C. Continue with the routine core inspections for the operations area. This will allow the resident inspectors to continue monitoring the problem areas described above.

Perform an one week inspection concentrating on operator personnel errors, the scope of the licensee's corrective actions, and the effectiveness of operator plant tours. This inspection will provide additional review of the licensee's corrective actions and the thoroughness of operator tours. Recommend that the back-up site SRI perform this inspection.

No deviations occurred from the previously planned inspection activities.

PPR STANDARD LETTER

Licensee distribution designate
Licensee name/address

SUBJECT: PLANT PERFORMANCE REVIEW (PPR) - SITE NAME

On (date), the NRC staff completed the semiannual Plant Performance Review (PPR) of (plant name). The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. The PPR for (plant name) involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period (months and years). PPRs provide NRC management with a current summary of licensee performance and serve as inputs to the NRC Systematic Assessment of Licensee Performance (SALP) and senior management meeting (SMM) reviews.

This letter advises you of our planned inspection effort resulting from the (plant name) PPR review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. The enclosure details our inspection plan for the next 6 months. The rationale or basis for each inspection outside the core inspection program is provided so that you are aware of the reason for emphasis in these program areas. (This sentence may be modified to provide additional emphasize regarding regional concerns of declining licensee performance. Specific examples that support the declining performance assessment should be listed.) Resident inspections are not listed due to their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact (DRP Branch Chief) at (telephone number).

(Signed by), Chief
Reactor Projects Branch
Division of Reactor Projects

Docket Nos. 50-ABC, 50-XYZ
License Nos. NPF-0, NPF-00

Enclosure: Inspection Plan

Attachment 2

PRE-DECISIONAL

PLANT NAME
INSPECTION PLAN

IP - Inspection Procedure

TI - Temporary Instruction

Core Inspection - Minimum NRC Inspection Program (mandatory all plants)

INSPECTION	TITLE/ PROGRAM AREA	NUMBER OF INSPECTORS	PLANNED INSPECTION DATES	TYPE OF INSPECTION - COMMENTS
IP 81700	Physical Security Program for Power Reactors	1	8/21-25/95	Core Inspection
TI 2515-109	Inspection Requirements for Generic Letter 89-10; S/R MOV Valve Testing and Surveillance; Rev. 1 (Part 2)	3	9/11-15/95	Area of Emphasis - Part 2 of TI involves evaluation of implementation by sampling of MOV's for detailed review
IP 83729	Occupational Exposure During Outages	2 (one trainee)	10/23-27/95	Initiative - Implementation of improvements for deficiencies in oversight and exposure controls for contract workers (IR 94-02; SALP 94-99)
IP 62700	Maintenance Program Implementation	2	11/13-17/95	Initiative - Emphasis on maintenance & testing of safety relief and power relief valves based on past problems (IR 94-24; LERs 94-10 & 94-17)
IP 84750	Radioactive Waste Treatment, and Effluent and Environmental Monitoring	1	1/8-12/95	Core Inspection

PRE-DECISIONAL

IP 64704	Fire Protection Program	1	2/12-16/95	Core Inspection
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Attachment 3

IF N
THE RECORD
CAN NOT INCLUDE

NOT IMPORTANT

IF ? WHETHER
ON LIST, AS IT CAN

Attachment 4

Number of Items 16

COULD BE
LIC DEC LINE
SELF ASSESSMENT
BUT MUST BE
PLANT NAME

PLANT ISSUES LIST

DATE	TYPE	SOURCE	ID	SFA	ITEM	APPARENT CAUSE/COMMENTS
11/14/95	WEAK	IR 95-20 URI	N	E	MSIV SOLENOID CONTINUITY TESTING NOT BEING PERFORMED PER UFSAR.	PERSONNEL ERROR DURING UFSAR CHANGE PREPARATION.
11/11/95	LER	IR 95-20	S	M	UNIT 2 REACTOR TRIP (RETURN TO OPERATION 11/12/95).	POWER LOSS TO BOTH ROD DRIVE MG SETS DUE TO LOOSE VOLTAGE REG FUSE HOLDERS.
11/8/95	VIO	IR 95-20 SL IV	L	M	FAILURE TO MEET T8 ACTION FOR INOPERABLE CONTAINMENT AIR LOCK DOOR.	CONT AIR LOCK PRESS TEST CONNECTION LEFT OPEN FOR 6 DAYS
11/3/95	STREN	IR 95-20	N	O	STRONG OPERATOR IDENTIFICATION OF AND RESPONSE TO MFRV PROBLEM.	OPERATOR ID SUBTLE FRV PROBLEM, CONTROLLED PLT WELL DURING REPAIRS.
11/1/95	WEAK	IR 95-20	N	E	POOR DOCUMENTATION OF SAFETY EVALUATIONS FOR ADMIN UFSAR CHANGES.	PERSONNEL ERROR DURING UFSAR CHANGE PREPARATION.
9/13/95	WEAK	IR 95-20	L	PS	IMPROPER PROCEDURE USE DURING CHEMICAL ADDITION FOR NON-SAFETY SYSTEM.	PERSONNEL ERROR.
9/7/95	NCV	IR 95-18 LER 95-04	L	M	N-16 MONITOR INOPERABLE. TS SURVEILLANCE MISSED FOR CONDENSER AIR EJECTOR GRAB SAMPLES.	SWITCH FOR SELECTING REACTOR POWER INPUT TO THE N-16 DETECTOR WAS STUCK.
8/30/95	STREN	IR 95-16	N	O	STRONG PROCESS FOR ORIGINATING AND TRACKING OPERATIONS IMPROVEMENT ITEMS.	OPERATIONS REVIEW BOARD USED TO TRACK/RESOLVE WORKAROUNDS.
8/21/95	NCV	IR 95-16	L	O	SPENT FUEL ROD STUCK WHEN RETURNING TO SPENT FUEL ASSEMBLY AFTER INSPECTIONS.	LOCATION ALREADY FILLED WITH ROD; INCORRECT ROD REMOVED FOR INSPECTION ON 08/04/95.

IN ADDITION TO
NEMINIST AND
MUST INCLUDE ALL LERs, NCVs, DFTs, NDET, TIA;
AND REPORTS TO
LIC APPROV REQUEST

FROM 6/1/95 TO: 12/30/95

PLANT NAME

Attachment 4

DATE	TYPE	SOURCE	ID	SFA	ITEM	APPARENT CAUSE/COMMENTS
8/9/95	WEAK	IR 95-15	N	E	WEAK DOCUMENT MANAGEMENT SYSTEM CONTRIBUTED TO MOV EVENT.	POOR USER INTERFACE & TRG RESULTED IN OUTDATED DRWG USED FOR FIELD WORK.
8/8/95	VIO	IR 95-15 SL IV	S	M	TWO CHARGING PUMP DISCHARGE MOVs OVERTHRUSTED.	MAINTENANCE TECH MADE UNREVIEWED CHANGE TO MOV WIRING.
8/1/95	STREN	IR 95-15	S	PS	STRONG PERFORMANCE ANNUNCIATOR PROGRAM IDENTIFIED ADVERSE HUMAN PERFORMANCE TREND.	GOOD STATION MANAGEMENT RESPONSE TO SELF-ASSESSMENT RESULTS.
7/16/95	VIO	IR 95-15 SL IV	N	M	MAINTENANCE ON ONE TRAIN SAVS INADVERTENTLY AFFECTED BOTH TRAINS.	OPERATIONS SUPPORT ERROR DURING WORK PLANNING.
7/7/95	WEAK	IR 95-14	N	E	WEAK ENGINEERING EVALUATION CONCERNING OPERABILITY FOR SW TO CHILLER PUMP FOLLOWING IST TEST FAILURE.	INATTENTION TO DETAIL BY IST ENGINEERS.
6/10/95	NCV	IR 95-15 LER 95-02	L	M	MISSED TS ACTION FOR AUTOMATIC RPI MONITORING OUT OF SERVICE.	TWO MAINTENANCE TECH ERRORS WHEN MANIPULATING PLANT COMPUTER.
6/6/95	VIO	IR 95-11 SL IV	N	M	SPENT FUEL HANDLED USING VENT SYSTEM WITH INOPERABLE HEATER.	OPERATOR UNAWARE OF STATUS; POOR SUPERVISION.

SALP Functional Areas:

E	ENGINEERING
M	MAINTENANCE
O	OPERATIONS
PS	PLANT SUPPORT

ID Code:

L	LICENSEE
N	NRC
S	SELF-REVEALED

SALEM

- **Poor Control of Plant Activities**
 - **Licensed Operator Errors**
- **Weak Problem Evaluation and Resolution**
 - **Ineffective Corrective Actions**

A/2

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PLANT: SALEM, Units 1 and 2, September 1995

AEOD CONCLUSIONS:

A review of LERs and NRC inspection reports (IRs) since October 1994 identified widespread problems resulting from poor control of plant activities. The plant submitted about twice the industry average number of LERs during this period, and most of these problems involved poor control of activities associated with a variety of plant departments. Most notable were the events involving licensed operator errors, where operators often appeared to be operating in an uncoordinated and poorly controlled manner. In particular, the licensed operators often failed to recognize and implement technical specification (TS) requirements.

AEOD's review also identified a long-standing deficiency in evaluating and resolving problems, which was similar to a deficiency identified at Hope Creek. As a result of this deficiency, corrective actions were either ineffective or not implemented in a timely manner. This allowed problems initially identified over a year ago to resurface, or similar problems to occur. This problem extended as far as the Station Operating Review Committee (SORC) which failed to demonstrate a systematic approach or questioning attitude towards safety issues. The failure to properly evaluate identified problems also resulted in several failures to implement reporting requirements.

PROBLEMS:

Poor Control of Plant Activities

The plant's high LER reporting rate over the last year primarily resulted from events involving poor control of plant activities. This problem existed in all aspects of plant operation, and involved operations, maintenance, and engineering activities. The problems stemmed from procedure deficiencies, ineffective administrative tracking systems, and personnel errors. Licensed operators frequently made errors that usually involved poor communication, distraction by other activities, or failures to verify or establish TS requirements. Examples include:

- The licensee entered the refueling mode at Unit 1 with inoperable containment isolation valves. This resulted from a procedure deficiency which allowed entry into the refueling mode without verifying containment purge system integrity. A previous operability evaluation determined the valves were unacceptable for containment isolation, but operators did not enter this in the TS tracking log. There was no procedural requirement to record TS action statements for future modes. (LER 272/95-19)

PREDECISIONAL

- The licensee paralleled all three Unit 1 emergency diesel generators (EDGs) to the grid, resulting in a potential common mode EDG failure. The licensed operators were not aware of Regulatory Guide 1.108 guidance on EDG testing. Procedures did not prohibit paralleling more than one EDG to the electrical grid at any one time. Also, operators did not understand TS action statement requirements for EDG testing when one or more EDGs are inoperable. (LER 272/95-07)
- The licensee rendered the control room emergency ventilation (CREV) systems on both units incapable of switching to the emergency recirculation mode. One of the radiation monitors, which the licensee repaired four months earlier, remained tagged out of service after the repairs. Licensed operators failed to verify the operability of that radiation monitor prior to shifting the CREV systems to a lineup which required the monitor. The licensee also attributed the event to poor CREV system procedural guidance. (LER 272/95-05)
- Licensed operators placed a Unit 1 power operated relief valve (PORV) in manual to support a surveillance, but failed to close the associated block valve within an hour as the TS required. Even though operators announced and logged the PORV inoperability, they failed to perform the TS required action until one day later. The licensed operators originally delayed closing the block valve, and subsequently became engaged in other work activities. (LER 272/95-02)
- Licensed operators allowed Unit 2 reactor coolant average temperature to decrease below the minimum requirement for criticality during a reactor startup. This resulted from making less than conservative decisions when operators performed reactor power manipulations with the main steam isolation valves closed and an atmospheric relief valve inoperable. Operators manually actuated an engineered safety features (ESF) isolation to close the steam line warmup and drain valves. Licensed operators failed to identify this as a reportable ESF, and did not make the required report to NRC until the next day. (LER 311/95-01)
- An unplanned TS 3.0.3 entry occurred at Unit 2 during a planned reactor coolant system heatup due to licensed operator failure to manually reinstate safety injection (SI) protection. Plant personnel blocked the automatic reinstatement of the SI protection when they performed a surveillance during the heatup. The plant subsequently operated above 545 degrees F with an inoperable loop temperature channel, without operators taking the required TS actions. This occurred due to placing the spare temperature detector into service when the normal detector failed calibration, without performing the required calibration on

the spare detector. The licensed operators performing this action failed to get the required Work Center Senior Reactor Operator's review. In addition, the temperature detector calibration procedure did not give guidance for a failed detector. (LER 311/94-16)

- NRC inspectors characterized the standards and expectations for the SORC as not well developed or communicated. The SORC failed to demonstrate a systematic approach or questioning attitude when reviewing or evaluating issues. Some issues included 10 CFR 50.59 safety assessments, and operability determinations involving the safety impact of certain degraded plant conditions. This weakness compounded the inspectors' previous concerns involving work planning and control effectiveness. (IR 95-07)

Weak Problem Evaluation and Resolution

Both LERs and NRC inspection reports identified examples of a long-standing deficiency in plant personnel's ability to evaluate and resolve problems. NRC inspectors were particularly critical of this aspect of the licensee's performance. AEOD identified a similar deficiency at the utility's Hope Creek plant. The failure to properly evaluate problems in the past resulted in ineffective corrective actions. This led to both recurrences of the past events, or experiencing events that the licensee previously identified as potential occurrences. In some cases, the failure to take effective corrective actions occurred over a year ago. Example include:

- A Unit 2 reactor scram occurred due to spurious operation of breaker failure protection circuitry during a manual shutdown. The circuitry vendor notified the licensee in 1993 of this potential, and recommended replacing a relay with an updated model. The licensee failed to act upon this recommendation until one month prior to this event, when the engineering department finally requested relay replacement. The licensee had not yet performed the replacement. (LER 311/95-04)
- The licensee's quality assurance department identified the failure to use the proper range of gauges for safety related pump inservice testing. The licensee initially identified the problem seven months earlier, but did not implement the corrective action (procedure revisions) for that discovery. (LER 272/95-18)

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- The licensee identified a discrepancy between the updated final safety analysis report and the steam line break analysis which affected containment penetration operability. The licensee failed to recognize this as a condition outside of the design basis until 16 months later. The LER stated the licensee was still evaluating the reason for the delay in recognizing the condition. (LERs 272/95-11 and 95-16)
- An EDG failed a surveillance test due to a vibration induced crack in a threaded cooling water jacket connection. Subsequent testing revealed the other EDGs were also susceptible to this failure. Similar failures occurred prior to 1983, but the design change package implemented in 1986 to correct the problem was ineffective. The licensee improperly used a schedule 40 fitting, instead of the required schedule 80 material, to repair another crack discovered in 1992. In 1993, the licensee repaired another fitting by grinding off the failed portion, rethreading the fitting, and reinstalling it. It was this same fitting which subsequently failed in this 1995 event. (LER 272/95-09)
- Unit 1 entered a TS 3.0.3 required shutdown when the licensee was unable to justify continued operation with two of three switchgear area supply fans inoperable. One fan failed in December 1994 and remained unrepaired. The second fan failed six months later from the same cause, lack of preventive maintenance on the motor bearings. The licensee continued to operate the plant for four more days before they determined that operation could not continue. Subsequent analysis determined that the initial failure in December 1994, for which no operability assessment was performed, placed the plant outside the design basis. (LER 272/95-08)
- NRC inspectors issued a Notice of Violation for a number of circuit breakers that failed from hardened and/or dirty grease in the operating mechanisms. In each case, the licensee narrowly focused the corrective actions on the repair of the individual failure. The licensee failed to promptly address the generic implications and potential safety significance of a condition that could result in the common mode failure of several components. (IR 95-12)
- NRC inspectors characterized the licensee as having demonstrated a tendency to avoid resolving problems promptly and evade making operability and corrective action decisions. Examples of this include the licensee:
 - failing to process emergent issues in accordance with their established procedures in a timely manner
 - subjecting the matters to lengthy analysis and indeterminate conclusion
 - attempting to justify continued operation with insufficient basis

~~PREDECISIONAL~~

The inspectors further characterized the licensee's approach to operability decision-making as often biased toward a positive determination without reference to, or consideration of, the applicable design basis. (IR 95-10)

- As of April 1995, the average age of work-arounds at Salem was 21.3 months, and 70 work-arounds still remained from the initial 80 in September 1994. (IR 95-80)

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SALEM 1

~~PREDECISIONAL~~

PREDECISIONAL PI EVENTS NOT INCLUDED IN THE 95-2 REPORT

NONE

MANUAL SCRAMS

NONE

ACCIDENT SEQUENCE PRECURSOR DATA

(*** DATA NOT AVAILABLE FOR 1994 OR 1995 ***)

EVENT DATE: 09/20/91
CDPR : 4.4E-6
DESC : BOTH PORVS FAILED DUE TO LEAKING ACTUATORS

EVENT DATE: 07/16/84
CDPR : 7.3E-6
DESC : HPIP FAIL TEST (RESIN PARTICLES/METAL FILINGS). ALL HPIP AFPE

OUTAGE DATA

FORCED

START DATE: 05/17/95
OUTAGE HRS: 2566.0 (106.9 Days)
DESC : THE #13 FAN MOTOR FAILED AND #12 WAS OUT OF SERVICE. JUSTIFICATION FOR CONTINUED OPERATION WITH ONE FAN COULD NOT BE OBTAINED. UNIT REMOVED FROM SERVICE ACCORDING TO TECH. SPEC. 3.0.3.

EQUIPMENT FORCED

START DATE: 02/20/95
OUTAGE HRS: 241.0 (10.0 Days)
DESC : 13MS10 CONTROLS.

FORCED

START DATE: 02/03/95
OUTAGE HRS: 391.9 (16.3 Days)
DESC : SSPS DESIGN INADEQUACY.

ABNORMAL OCCURRENCES (AO)

NONE

SALEM 1

PREDECISIONAL

AO APPENDIX C - OTHER EVENTS OF INTEREST

NONE

EVENTS AEOD CONSIDERS IMPORTANT

EVENT DATE: 05/05/95

DESC : LER 95-007-00: ON 950505, EDGS 1A, 1B & 1C SIMULTANEOUSLY PARALLELED TO ELECTRICAL GRID, RESULTING IN POTENTIAL FOR COMMON MODE FAILURE OF ALL THREE EDGS. CAUSED BY MGT/QA DEFICIENCY. PROCEDURES REVISED. W/950602 LTR.

EVENT DATE: 02/01/95

DESC : LER 95-001-00: ON 950201, BOTH SSPS TRAINS DECLARED INOPERABLE AFTER DISCOVERY THAT AC POWER DISTRIBUTION WITHIN SSPS SUSCEPTIBLE TO COMMON MODE FAILURE. CAUSED BY AGED COMPONENTS. NEW POWER SUPPLIES INSTALLED. W/950302 LTR.

EVENT DATE: 12/09/94

DESC : LER 94-018-00: ON 941209, SAFEGUARDS EQUIPMENT CABINET (SEC) 1A DECLARED INOPERABLE DUE TO SEQUENCING PROBLEM & TS 3. O. 3 ENTERED. ROOT CAUSE ANALYSIS WILL BE PERFORMED. REPT ALSO INTENDED TO SATISFY REQUIREMENTS OF 10CFR21. W/950104 LTR.

EVENT DATE: 11/17/94

DESC : LER 94-017-00: ON 941117, LISTED ASSUMPTIONS COULD PLACE UNIT 1 OUTSIDE DESIGN/LICENSING BASIS FOR POPS ANALYSIS. PDP OPERATION NOT CONSIDERED IN ANY DESIGN BASIS PRESSURE LIMIT OF 450 PSIG. W/941214 LTR.

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SALEM 1

92-3 to 95-2

Quarterly Data

Legend:

Shutdown < approx. 72 hrs. |

Refueling R

Industry Avg. Trend —

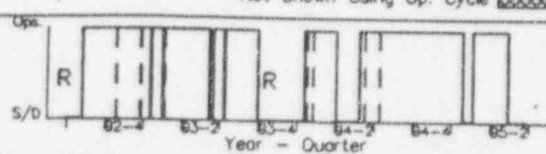
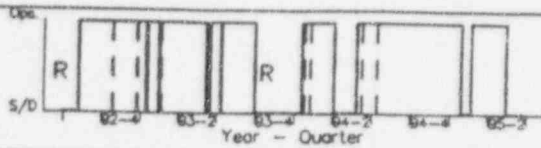
Not Shown Using Op. Cycle

StartUp

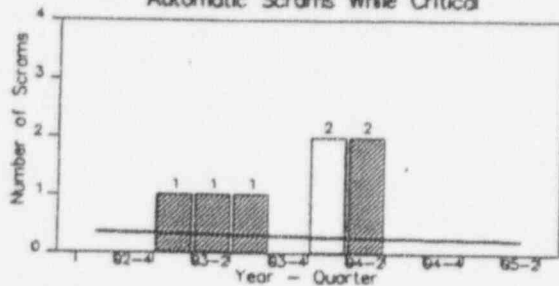
Operation

Shutdown

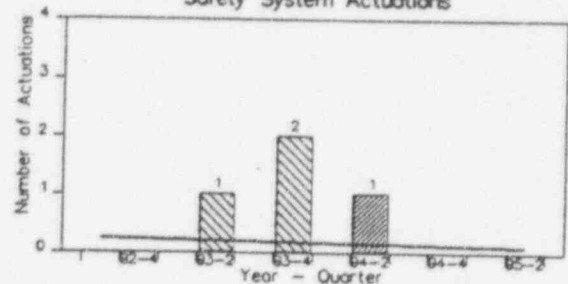
Not Shown Using Op. Cycle



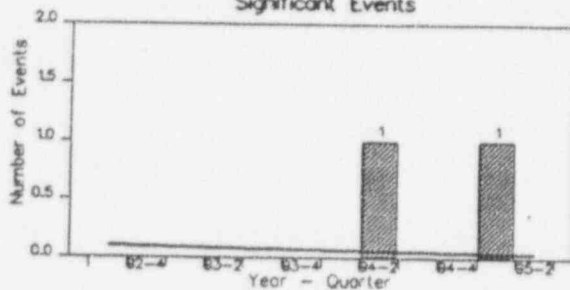
Automatic Scrams While Critical



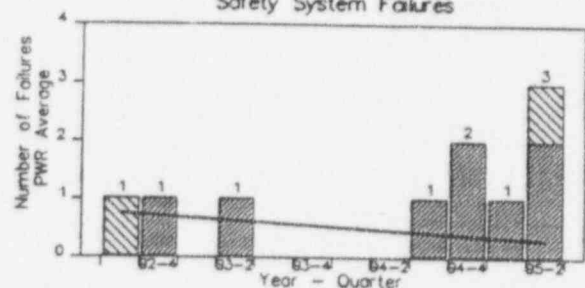
Safety System Actuations



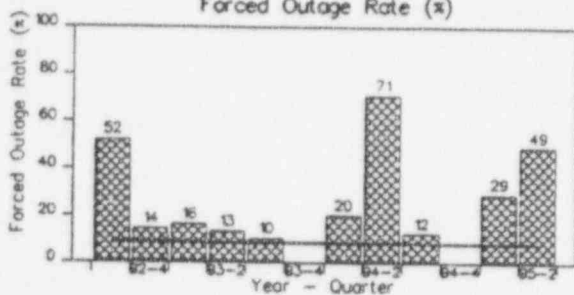
Significant Events



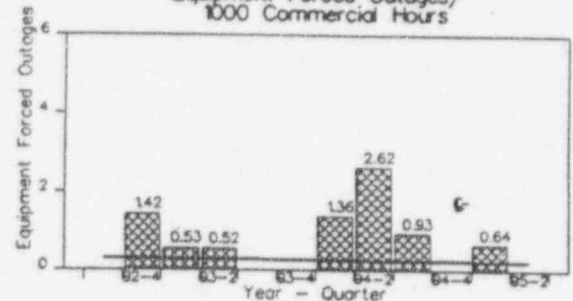
Safety System Failures



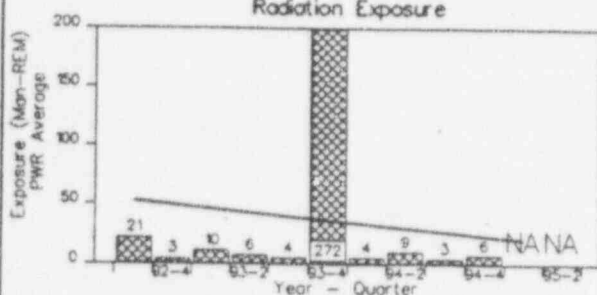
Forced Outage Rate (%)



Equipment Forced Outages/
1000 Commercial Hours



Radiation Exposure



• Unit Specific Radiation Exposure

Cause Codes

a. Admin

b. Lic Oper

c. Other Per

d. Maint

e. Design

f. Misc.

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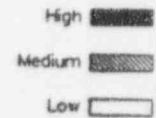
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0 5 10 15

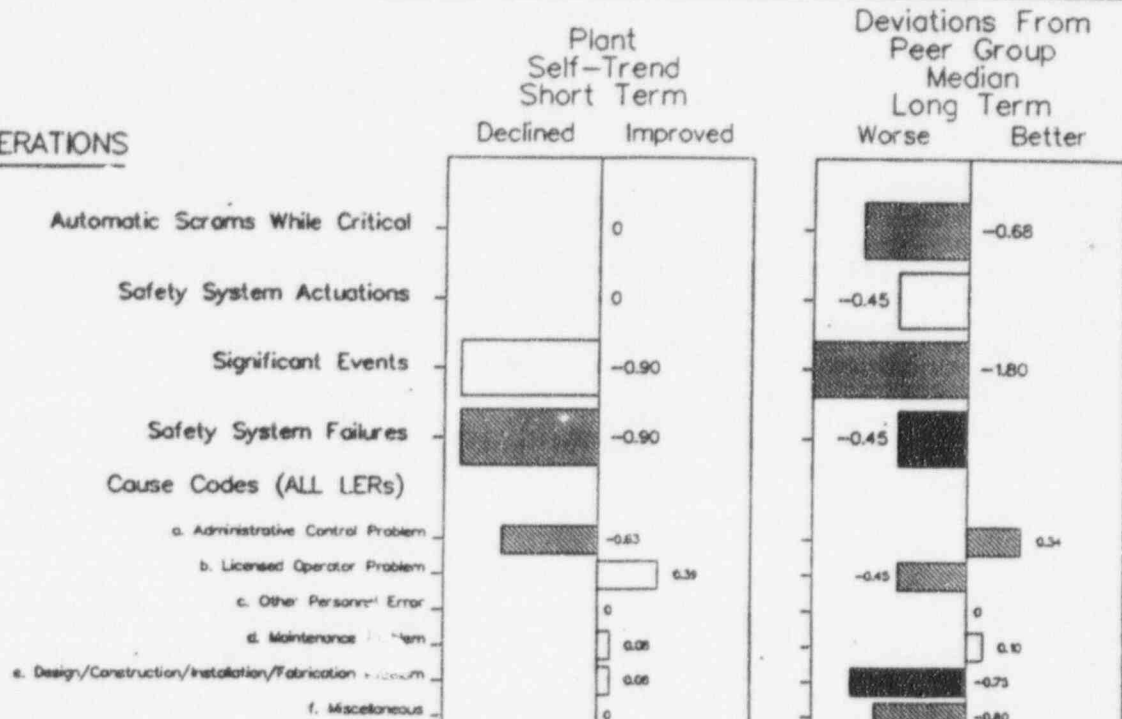
SALEM 1

Peer Group: Older Westinghouse 4-Loop
92-3 to 95-2 Trends and Deviations

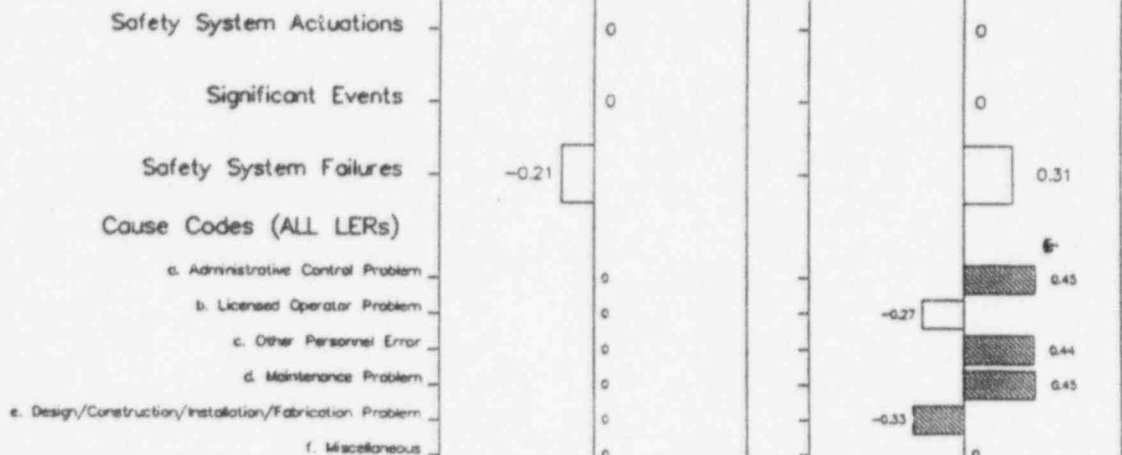
Legend: Statistical Significance



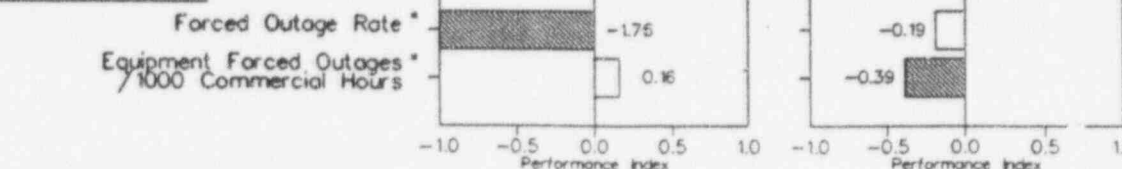
OPERATIONS



SHUTDOWN



FORCED OUTAGES



* Not Calculated for Operational Cycle

SALEM 1

PI EVENTS FOR 94-3

SSF 07/25/94 LER# 27294013 50.72#:
 PWR HIST: EVENT DISCOVERED DURING OPERATION AT 100% POWER.
 GROUP : CONTAINMENT AND CONTAINMENT ISOLATION GROUP
 SYSTEM : CONTAINMENT ISOLATION CONTROL SYSTEM
 DESC : A CONTAINMENT PRESSURE RELIEF EVOLUTION WAS PERFORMED WITH THE AUTOMATIC ISOLATION CAPABILITY INOPERABLE.

PI EVENTS FOR 94-4

SSF 11/17/94 LER# 27294017 50.72#: 28043
 PWR HIST: CONDITION EXISTED IN ALL MODES UP TO 100% POWER SINCE INITIAL OPERATION
 GROUP : LOW TEMPERATURE/OVERPRESSURE PROTECTION GROUP
 SYSTEM : LOW TEMP/OVERPRESSURE PROTECTION SYSTEM
 DESC : THE LOW TEMPERATURE OVER PRESSURE PROTECTION SYSTEM WOULD NOT PROVIDE ADEQUATE PROTECTION DURING CERTAIN OVER PRESSURE EVENTS DUE TO INADEQUATE DESIGN CONSIDERATIONS.

SSF 12/09/94 LER# 27294018 50.72#: 28127
 PWR HIST: EVENT DISCOVERED DURING OPERATION AT 100% POWER.
 GROUP : ENGINEERED SAFETY FEATURES INSTRUMENTATION
 SYSTEM : ENGINEERED SAFETY FEATURES ACTUATION SYSTEM
 DESC : BOTH SAFEGUARDS EQUIPMENT CABINETS WERE DECLARED INOPERABLE. A TEST PUSH BUTTON IN ONE CABINET STUCK IN THE DEPRESSED POSITION WHILE THE OTHER CABINET WAS INOPERABLE BECAUSE A RELAY WAS STUCK CLOSED.

PI EVENTS FOR 95-1

SSF 02/01/95 LER# 27295001 50.72#: 28321
 PWR HIST: CONDITION EXISTED IN ALL MODES UP TO 100% POWER SINCE INITIAL OPERATION
 GROUP : ENGINEERED SAFETY FEATURES INSTRUMENTATION
 SYSTEM : MULTIPLE SYSTEMS
 OTH UNIT: THIS EVENT WAS ASSIGNED TO UNITS 1 AND 2.
 DESC : THE SOLID STATE PROTECTION SYSTEM WAS DECLARED INOPERABLE BECAUSE OF THE POWER FEED TO FIELD CIRCUITS. THE DESIGN WAS SUSCEPTIBLE TO A COMMON CAUSE FAILURE.

SE 02/01/95 LER# 27295001 50.72#: 28321
 PWR HIST: CONDITION EXISTED IN ALL MODES UP TO 100% POWER SINCE INITIAL OPERATION
 OTH UNIT: THIS EVENT WAS ASSIGNED TO UNITS 1 AND 2.
 DESC : THE AC POWER DISTRIBUTION FOR THE SOLID STATE PROTECTION SYSTEM WAS SUSCEPTIBLE TO A COMMON MODE FAILURE. A SHORT IN A NON-SAFETY RELATED CIRCUIT COULD DEENERGIZE THE SAFETY RELATED POWER SUPPLIES AND PREVENT AUTO-ACTUATIONS OF BOTH SSPS TRAINS.

PI EVENTS FOR 95-2

SSF 05/05/95 LER# 27295007 50.72#: 28771
 PWR HIST: EVENT OCCURRED DURING OPERATION AT 58% POWER
 GROUP : EMERGENCY AC/DC POWER SYSTEMS GROUP
 SYSTEM : EMERGENCY ONSITE POWER SUPPLY SYSTEM
 DESC : ALL THREE EDGS WERE SIMULTANEOUSLY PARALLELED TO THE ELECTRICAL GRID. THIS RESULTED IN THE POTENTIAL FOR A COMMON MODE FAILURE OF ALL THREE EDGS. THE CAUSE WAS ATTRIBUTED TO MANAGEMENT/QA DEFICIENCY.

SSF 05/16/95 LER# 27295008 50.72#: 28812
 PWR HIST: EVENT DISCOVERED DURING OPERATION AT 95% POWER.
 GROUP : EMERGENCY AC/DC POWER SYSTEMS GROUP
 SYSTEM : MEDIUM-VOLTAGE POWER SYSTEM - CLASS 1E
 DESC : TWO OF THREE SWITCHGEAR ROOM SUPPLY FANS WERE INOPERABLE. THIS COULD RENDER VITAL EQUIPMENT AND TRANSFORMERS INOPERABLE AS THE RESULT OF HIGH TEMPERATURES. A PREVENTIVE MAINTENANCE PROGRAM DID NOT EXIST FOR THE FAN MOTORS.

SALEM 1

PI EVENTS FOR 95-2 (CONT.)

SSF 06/08/95 LER# 27295009 50.72#: 28908
PWR HIST: EVENT DISCOVERED IN COLD SHUTDOWN.
GROUP : EMERGENCY AC/DC POWER SYSTEMS GROUP
SYSTEM : EMERGENCY ONSITE POWER SUPPLY SYSTEM
DESC : WITH ONE EDG UNAVAILABLE FOR MAINTENANCE, A COMMON DESIGN PROBLEM WAS DISCOVERED WITH THE JACKET
WATER COOLING SYSTEM THAT COULD RENDER THE OTHER TWO EDGS INOPERABLE.

SALEM 1

PREDECISIONAL DEVIATION ANALYSIS REPORT

LISTED BELOW ARE EXPLANATIONS FOR THE NEGATIVE BLACK DEVIATION BARS IN THE 95-2 PI REPORT:

SSFS

THE SAFETY SYSTEM FAILURE DEVIATION DURING OPERATIONS RESULTED FROM SIX EVENTS THAT OCCURRED IN LATE 1994 AND EARLY 1995. THIS WAS THE MOST EVENTS EXPERIENCED BY ANY OF THE NINE PLANTS IN THE PEER GROUP. HALF OF THE EVENTS WERE ACTUAL FAILURES. THE PEER GROUP AVERAGE WAS 2.4 EVENTS.

CAUSE CODES

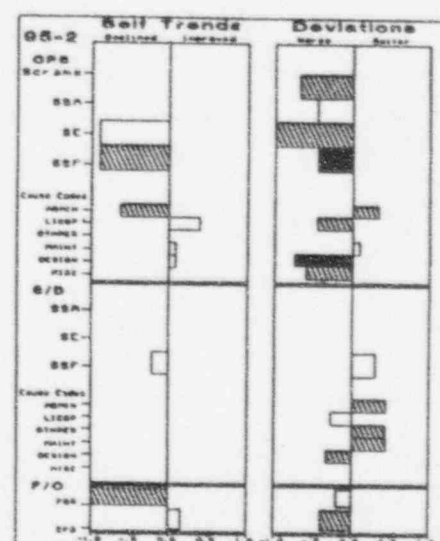
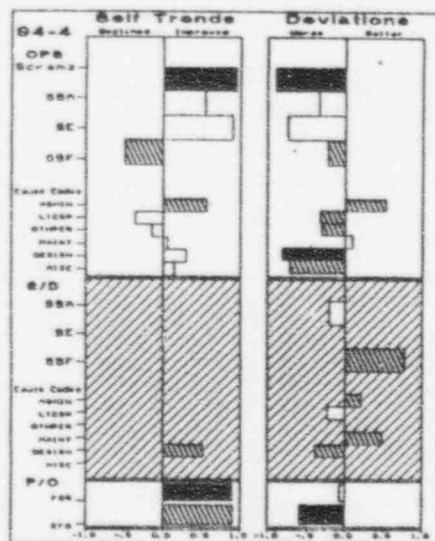
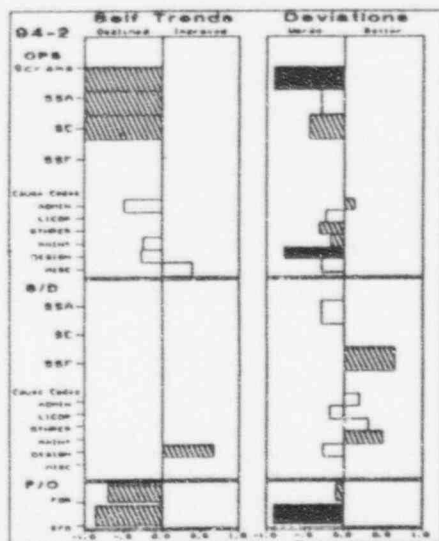
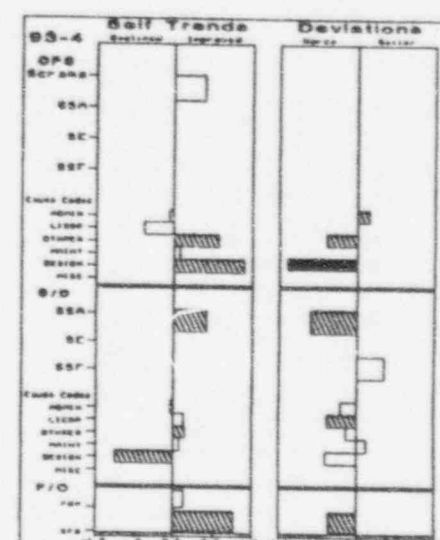
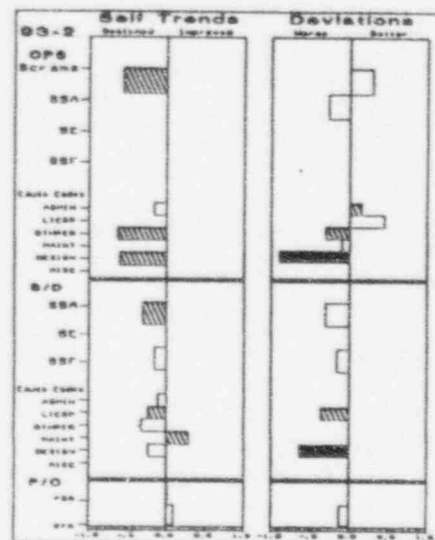
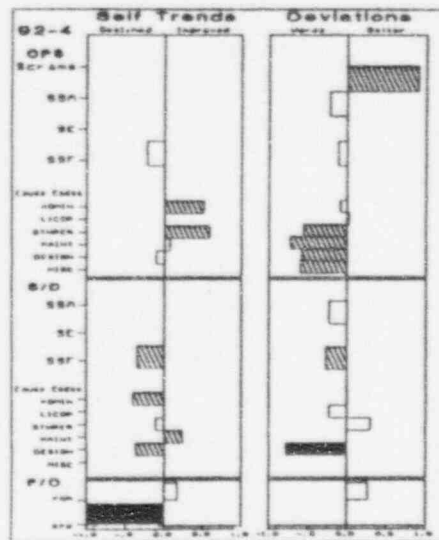
DESIGN

THE DESIGN CAUSE CODE DEVIATION DURING OPERATIONS RESULTED FROM 15 EVENTS, MOST OF WHICH OCCURRED IN 1994. THIS WAS THE MOST EVENTS EXPERIENCED BY ANY OF THE NINE PLANTS IN THE PEER GROUP. TEN OF THE EVENTS WERE TECHNICAL SPECIFICATION VIOLATIONS, SEVEN OF WHICH INVOLVED TECHNICAL SPECIFICATION 3.0.3 ENTRIES DUE TO PROBLEMS WITH THE ANALOG ROD POSITION INDICATION SYSTEM. THE PEER GROUP AVERAGE WAS 7.2 EVENTS.

SALEM 1

Trends & Deviations

PREDECISIONAL



Shaded Regions: Inadequate phase time in last 2 quarters to update calculations

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SALEM 2

PREDECISIONAL

PREDECISIONAL PI EVENTS NOT INCLUDED IN THE 95-2 REPORT

NONE

MANUAL SCRAMS

NONE

ACCIDENT SEQUENCE PRECURSOR DATA

(*** DATA NOT AVAILABLE FOR 1994 OR 1995 ***)

EVENT DATE: 12/20/90
CDPR : 1.3E-6
DESC : S1 AND ONE TRAIN OF EMERGENCY POWER INOPERABLE

EVENT DATE: 01/17/90
CDPR : 1.3E-6
DESC : HPI INOPERABLE DUE TO LEAKING WELD

EVENT DATE: 08/27/85
CDPR : 7.1E-6
DESC : #21 CCWHX IN MAINT. #22 CCWHX OUTLET VALVE FAILS CLOSED.

OUTAGE DATA

EQUIPMENT FORCED

START DATE: 06/07/95
OUTAGE HRS: 2041.0 (85.0 Days)
DESC : BREAKER FAILURE 1-9 500KV.

EQUIPMENT FORCED

START DATE: 02/19/95
OUTAGE HRS: 421.0 (17.5 Days)
DESC : 21 RCP SEAL.

FORCED

START DATE: 02/03/95
OUTAGE HRS: 291.3 (12.1 Days)
DESC : SSPS DESIGN INADEQUACY.

SCHEDULED

START DATE: 10/13/94
OUTAGE HRS: 2715.0 (113.1 Days)
DESC : NORMAL REFUELING.

SALEM 2

PREDECISIONAL

ABNORMAL OCCURRENCES (AO)

NONE

AO APPENDIX C - OTHER EVENTS OF INTEREST

NONE

EVENTS AEOD CONSIDERS IMPORTANT

EVENT DATE: 11/18/94

DESC : LER 94-014-00: ON 941118, NUMBER 4 STATION POWER TRANSFORMER TRIPPED RESULTING IN
"BLACKOUT SIGNAL. " CAUSED BY FAILURE OF STATION POWER TRANSFORMER OR SWITCHER 125 4T60.
STRIP CHART RECORDER INSTALLED. W/941214 LTR.

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SALEM 2

92-3 to 95-2

Quarterly Data

Legend:

Shutdown < approx. 72 hrs. I

Refueling R

Industry Avg. Trend

I

R

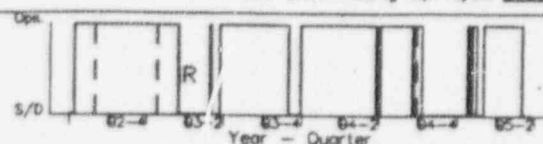
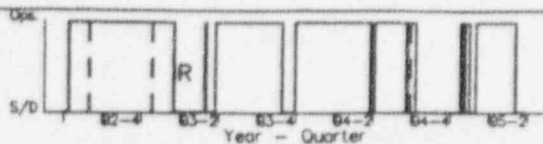
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StartUp

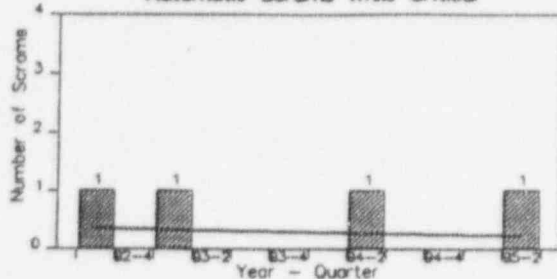
Operation

Shutdown

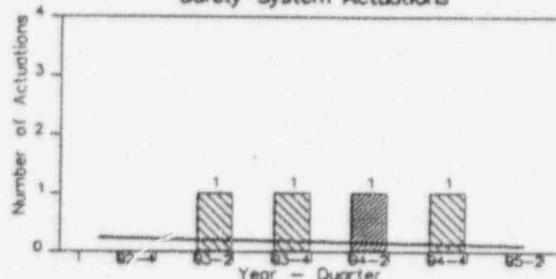
Not Shown Using Op. Cycle



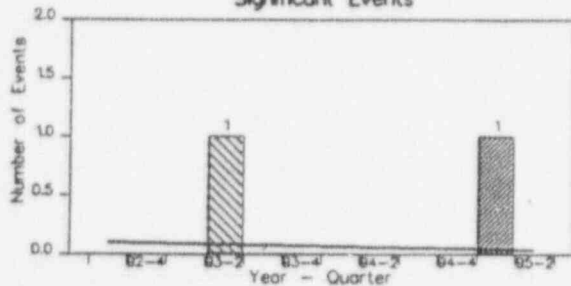
Automatic Scrams While Critical



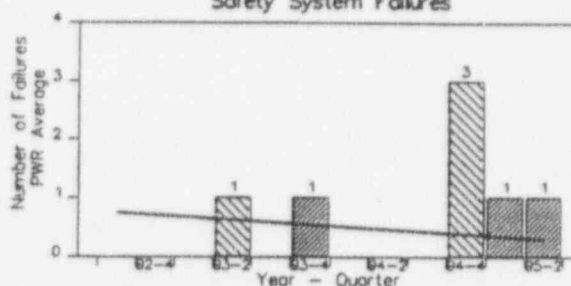
Safety System Actuations



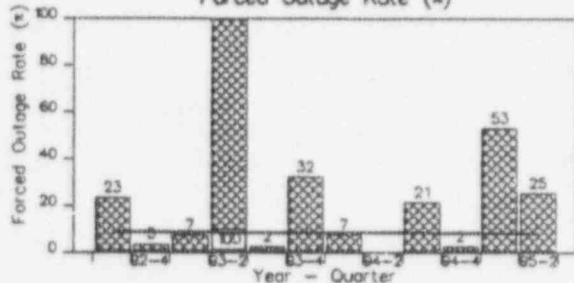
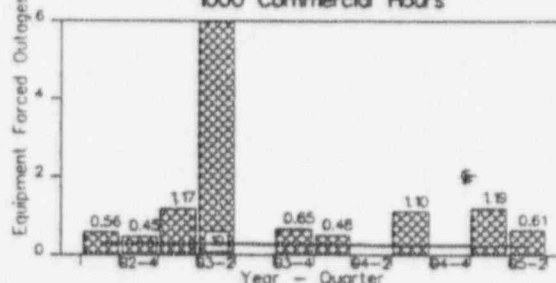
Significant Events



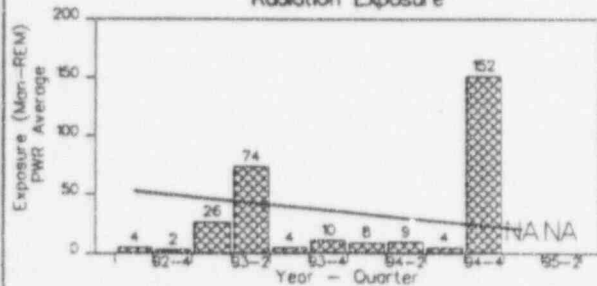
Safety System Failures



Forced Outage Rate (%)

Equipment Forced Outages/
1000 Commercial Hours

Radiation Exposure



• Unit Specific Radiation Exposure

Cause Codes

a. Admin

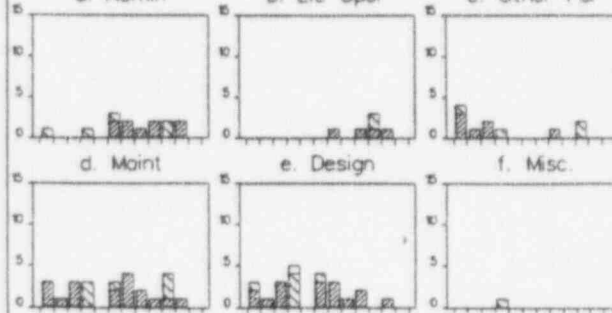
b. Lic Oper

c. Other Per

d. Maint

e. Design




f. Misc.



SALEM 2

Peer Group: Older Westinghouse 4-Loop
92-3 to 95-2 Trends and Deviations

Legend: Statistical Significance

High 
Medium 
Low 

OPERATIONS

Automatic Scrams While Critical

Safety System Actuations

Significant Events

Safety System Failures

Cause Codes (ALL LERs)

a. Administrative Control Problem

b. Licensed Operator Problem

c. Other Personnel Error

d. Maintenance Problem

e. Design/Construction/Installation/Fabrication Problem

f. Miscellaneous

SHUTDOWN

Safety System Actuations

Significant Events

Safety System Failures

Cause Codes (ALL LERs)

a. Administrative Control Problem

b. Licensed Operator Problem

c. Other Personnel Error

d. Maintenance Problem

e. Design/Construction/Installation/Fabrication Problem

f. Miscellaneous

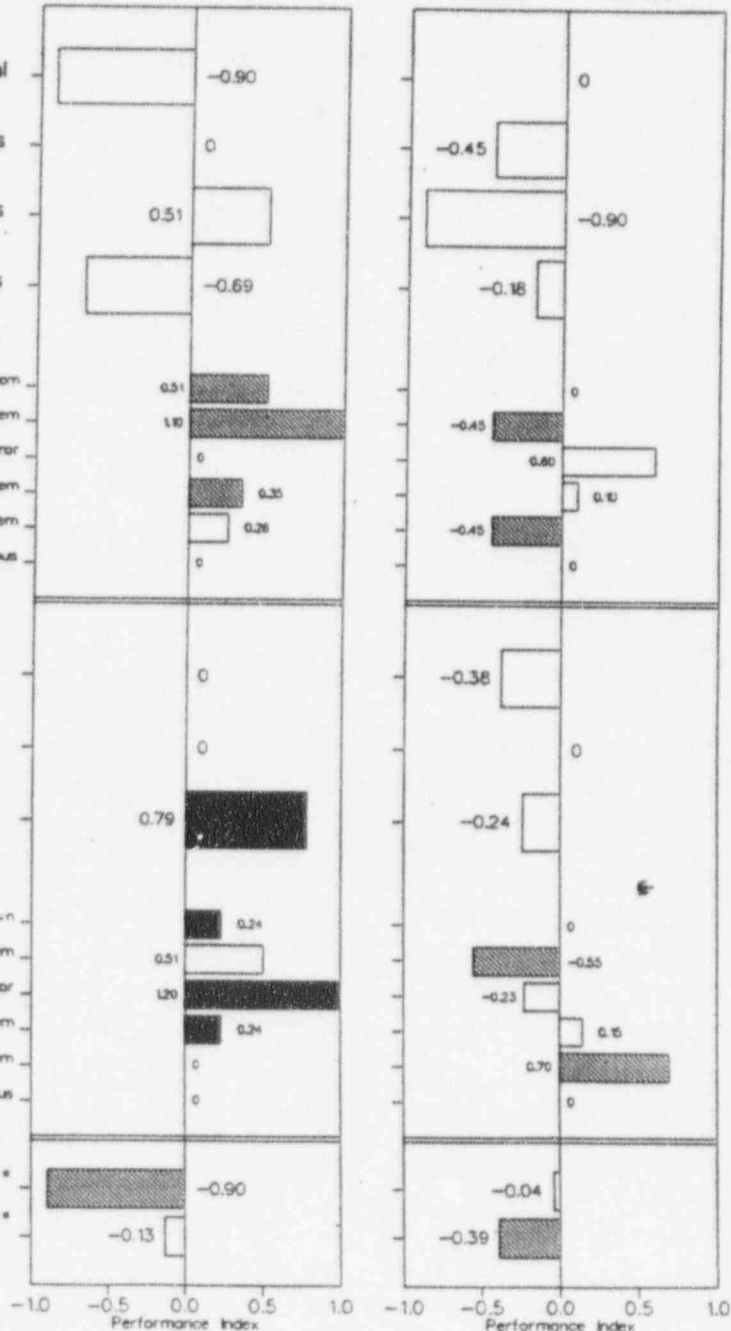
FORCED OUTAGES

Forced Outage Rate *

Equipment Forced Outages *
/1000 Commercial Hours

Plant
Self-Trend
Short Term
Declined Improved

Deviations From
Peer Group
Median
Long Term
Worse Better



* Not Calculated for Operational Cycle

SALEM 2

PI EVENTS FOR 94-3

NONE

PI EVENTS FOR 94-4

SSF 10/23/94 LER# 31194013 50.72#:
 PWR HIST: EVENT DISCOVERED IN COLD SHUTDOWN.
 GROUP : CONTAINMENT AND CONTAINMENT ISOLATION GROUP
 SYSTEM : REACTOR CONTAINMENT BUILDING
 DESC : CONTAINMENT INTEGRITY WAS VIOLATED WHEN SERVICE WATER PIPING VENT AND DRAIN VALVES WERE TAGGED OPEN DURING REACTOR HEAD REMOVAL, CORE ALTERATIONS, AND MOVEMENT OF IRRADIATED FUEL.

SSA 11/18/94 LER# 31194014 50.72#: 28045 PWR HIST: REFUELING
 DESC : AN AUTOSTART OF THE EMERGENCY DIESELS OCCURRED WHEN A LOAD DISCONNECT OPENED AS A RESULT OF THE INTERMITTENT COMPONENT FAILURE OF TWO CONTROL RELAYS.

SSF 12/26/94 LER# 31194016 50.72#:
 PWR HIST: EVENT DISCOVERED IN HOT STANDBY
 GROUP : EMERGENCY CORE COOLING SYSTEMS GROUP
 SYSTEM : HIGH PRESSURE SAFETY INJECTION SYSTEM
 DESC : THE HIGH STEAM FLOW/LOW TAVE SAFETY INJECTION SIGNAL WAS BLOCKED FOR APPROXIMATELY 15 MINUTES WHEN PERSONNEL FAILED TO FOLLOW A CALIBRATION PROCEDURE. THIS WAS THE FIRST OF TWO SIMILAR EVENTS.

SSF 12/27/94 LER# 31194016 50.72#:
 PWR HIST: EVENT DISCOVERED IN HOT STANDBY
 GROUP : EMERGENCY CORE COOLING SYSTEMS GROUP
 SYSTEM : HIGH PRESSURE SAFETY INJECTION SYSTEM
 DESC : THE HIGH STEAM FLOW/LOW TAVE SAFETY INJECTION SIGNAL WAS BLOCKED FOR APPROXIMATELY 14 DAYS DUE TO FAILURE TO FOLLOW A CALIBRATION PROCEDURE. THIS WAS THE SECOND OF TWO SIMILAR EVENTS.

PI EVENTS FOR 95-1

SSF 02/01/95 LER# 27295001 50.72#: 28321
 PWR HIST: CONDITION EXISTED IN ALL MODES UP TO 100% POWER SINCE INITIAL OPERATION
 GROUP : ENGINEERED SAFETY FEATURES INSTRUMENTATION
 SYSTEM : MULTIPLE SYSTEMS
 OTH UNIT: THIS EVENT WAS ASSIGNED TO UNITS 1 AND 2.
 DESC : THE SOLID STATE PROTECTION SYSTEM WAS DECLARED INOPERABLE BECAUSE OF THE POWER FEED TO FIELD CIRCUITS. THE DESIGN WAS SUSCEPTIBLE TO A COMMON CAUSE FAILURE.

SE 02/01/95 LER# 27295001 50.72#: 28321
 PWR HIST: CONDITION EXISTED IN ALL MODES UP TO 100% POWER SINCE INITIAL OPERATION
 OTH UNIT: THIS EVENT WAS ASSIGNED TO UNITS 1 AND 2.
 DESC : THE AC POWER DISTRIBUTION FOR THE SOLID STATE PROTECTION SYSTEM WAS SUSCEPTIBLE TO A COMMON MODE FAILURE. A SHORT IN A NON-SAFETY RELATED CIRCUIT COULD DEENERGIZE THE SAFETY RELATED POWER SUPPLIES AND PREVENT AUTO-ACTUATIONS OF BOTH SSPS TRAINS.

PI EVENTS FOR 95-2

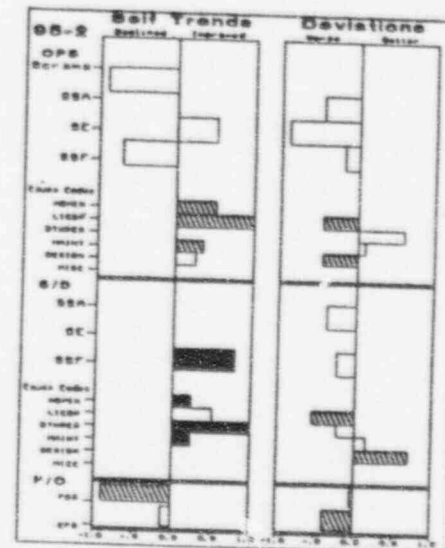
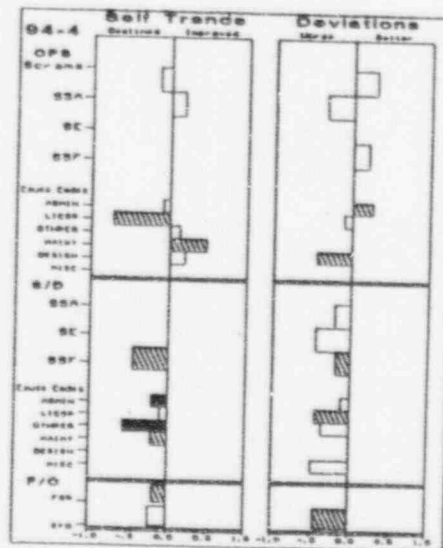
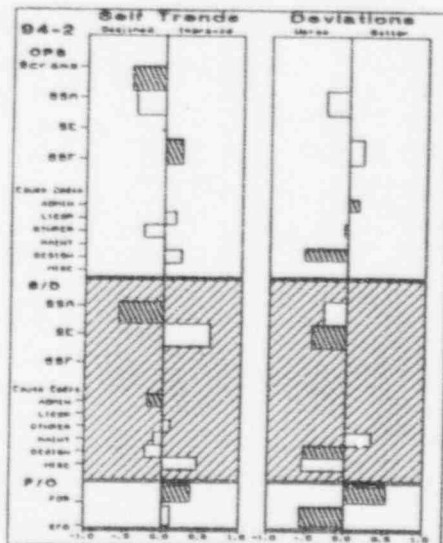
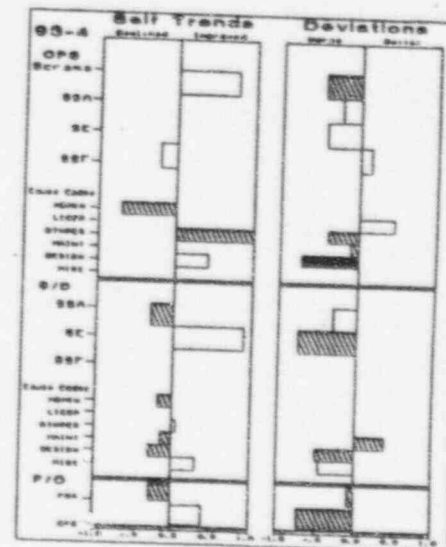
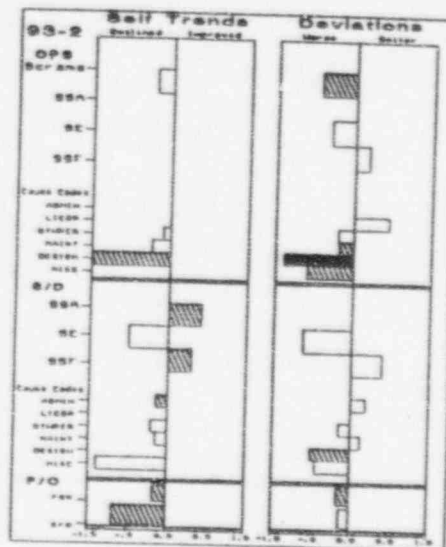
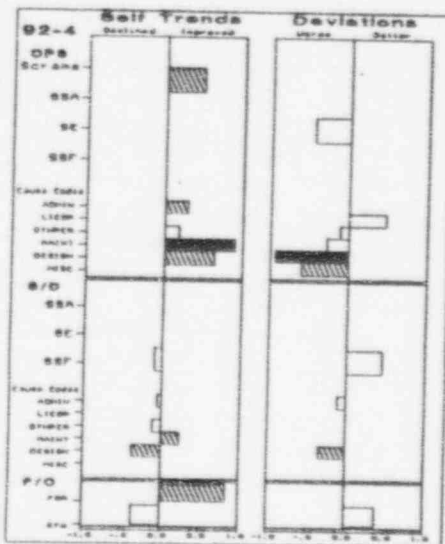
SCRAM 06/07/95 LER# 31195004 50.72#: 28907 PWR HIST: TRIP FROM 14% FOLLOWING REDUCTION FROM 100%
 DESC : A REACTOR TRIP OCCURRED ON LOW REACTOR COOLANT FLOW WHEN A SWITCHYARD BREAKER OPENED UNEXPECTEDLY DURING A SHUTDOWN. A MALFUNCTION OF THE BREAKER FAILURE RELAY OCCURRED.

SSF 06/07/95 LER# 31195004 50.72#: 28904
 PWR HIST: EVENT DISCOVERED DURING OPERATION AT 100% POWER.
 GROUP : EMERGENCY CORE COOLING SYSTEMS GROUP
 SYSTEM : LOW PRESSURE SAFETY INJECTION SYSTEM
 DESC : BOTH TRAINS OF LPSI WERE DECLARED INOPERABLE DUE TO PROBLEMS WITH THE RHR PUMP RECIRCULATION VALVES. ONE PUMP RECIRCULATION VALVE FAILED TO OPEN AND OPERABILITY OF THE OTHER PUMP'S RECIRCULATION VALVE COULD NOT BE ENSURED.

SALEM 2

Trends & Deviations

PREDECISIONAL



Shaded Regions: Inadequate phase time in last 2 quarters to update calculations

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