United States Nuclear Regulatory Commission
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By Primary Functional Area / Issue Date

Region I

PEACH BOTTOM

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
12/27/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 5B **Sec:** 5A **Ter:** 5C	**ORGANIZATIONAL SELF-ASSESSMENTS** The quality of PECO's 1999 self-assessments had improved. These assessments were in-depth and resulted in significant findings. These identified problems were entered into PECO's corrective action program with identified problems scheduled for timely resolution.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
12/27/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 5B **Sec:** 5C **Ter:**	**ROOT CAUSE EVALUATIONS** The root cause evaluations for Performance Enhancement Program (PEP) issues performed at Peach Bottom in 1999 were generally good and contained thorough investigations of the issues. The identified corrective actions for resolving these issues were appropriate. The corrective actions were either adequately implemented or being tracked for completion through the PEP tracking system. The root cause evaluation process and corrective action implementation had improved at the station in 1999.
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12/27/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 5C **Sec:** 5B **Ter:**	**EFFECTIVENESS OF RESOLUTIONS FOR IDENTIFIED ISSUES** PECO's resolutions for identified issues were effective. The recurrence of identified issues was very low.
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12/27/1999	1999009-01	**Pri:** OPS **Sec:**	Licensee	NCV	**Pri:** 2A **Sec:** 5A **Ter:**	**CORE SPRAY PUMP ROOM COOLER FAN FAILED TO START** The 2B core spray subsystem was inoperable for a time period greater than allowed by Technical Specifications because the associated room cooler fan would not auto-start. This violation is being treated as a Non-Cited Violation (NCV) consistent with Section VII.B.1.a of the NRC Enforcement Policy.
Dockets Discussed: 05000277 Peach Bottom 2						
11/08/1999	1999008	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**UNIT 2 TURBINE TRIP AND REACTOR SCRAM REVIEW** Operations personnel generally performed well following the turbine trip and subsequent scram of the Unit 2 reactor on September 30, 1999. The station staff appropriately evaluated the causes of the automatic shutdown and appropriate equipment problems. Overall, the station review committee performed a thorough review of the event. The inspectors noted that some engineering inputs into the process were initially deficient. Station personnel identified and corrected the causes of the turbine trip and other equipment problems that occurred during the event.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
11/08/1999	1999008	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 1C **Ter:**	**RESPONSE TO NEGATIVE TREND IN PROCEDURE ADHERENCE** Operations personnel took prompt, pro-active actions in response to a negative trend in procedure adherence by operators during the Unit 3 shutdown.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						

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11/08/1999	1999008-01	**Pri:** OPS **Sec:**	Licensee	NCV	**Pri:** 2A **Sec:** 2B **Ter:**	**UNIT 2 REACTOR COOLANT SYSTEM HEATUP GRATER THAN 100 DEGREES F/HOUR** Following the reactor scram on September 30, 1999, a heatup rate of 170 F in 45 minutes occurred in the 2A recirculation loop. The root cause of this event, as presented in the licensee event report, was in error and will be revised to reflect that the unreliable bottom head drain temperature indication prevented starting a recirculation pump. Procedural problems were a contributing factor in this event and PECO was reviewing the procedures for revision. The heatup of the recirculation system in excess of the technical specification limit of 100 F/hr is a Severity Level IV violation and is being treated as a Non-Cited Violation (NCV) consistent with Section VII.B.1.a of the NRC Enforcement Policy.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
09/20/1999	1999007	**Pri:** OPS **Sec:**	Self	POS	**Pri:** 1B **Sec:** 3A **Ter:**	**TRIP OF THE 3A REACTOR FEEDWATER PUMP DUE TO A FAILED UNINTERRUPTIBLE POWER SUPPLY BATTEI** Main control room personnel performed well while responding to the plant transient that resulted from the trip of the 3A reactor feedwater pump. Site engineering personnel took reasonable actions to recover and restore the reactor feed pump governor uninterruptible power supply (UPS).
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
09/13/1999	1999302	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3B **Ter:**	**REACTOR OPERATOR (RO) AND SENIOR REACTOR OPERATOR INSTANT (SROI) INITIAL EXAMINATIONS** Two reactor operator (RO) and three senior reactor operator instant (SROI) applicants were well prepared for the September 1999 operator licensing examinations. The facility used an examination preparation team of experienced training department staff who assisted the NRC examiners in an excellent manner.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
09/30/1999	2-99-006-00	**Pri:** OPS **Sec:**	Licensee	LER	**Pri:** **Sec:** **Ter:**	**ENGINEERED SAFETY FEATURE ACTUATIONS FOLLOWING THE TURBINE TRIP AND THE REQUIREMENTS OF 1** ON THURSDAY, SEPTEMBER 30, 1999 AT APPROXIMATELY 19:06 HOURS, WITH UNIT 2 OPERATING AT 100 PERCENT POWER, A GENERATOR LOCKOUT AND SUBSEQUENT TURBINE TRIP OCCURRED THAT RESULTED IN A REACTOR SCRAM. THE TURBINE TRIP CAUSED A HIGH REACTOR PRESSURE CONDITION RESULTING IN THREE MAIN STEAM RELIEF VALVES (MSRV) LIFTING AND AN ALTERNATE ROD INSERTION (ARI) INITIATION. ADDITIONALLY, PRIMARY CONTAINMENT ISOLATION SYSTEM (PCIS) GROUP II AND GROUP III ISOLATIONS OCCURRED DUE TO LOW REACTOR WATER LEVEL FOLLOWING THE SCRAM.
Dockets Discussed: 05000277 Peach Bottom 2						
08/09/1999	1999006	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 3A **Ter:**	**CONDUCT OF OPERATIONS** Operations and engineering personnel performed very well while addressing high temperature conditions that affected several systems and components during a period of hot weather.
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08/09/1999	1999006	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** 3A **Ter:**	**2B REACTOR FEED PUMP TRIP** Operators performed well in response to a trip of the 2B reactor feed pump and the subsequent recirculation system runback.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
08/09/1999	1999006	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 1C **Ter:**	**UNIT 2 RESIDUAL HEAT REMOVAL SYSTEM LOGIC SYSTEM FUNCTIONAL TEST PROCEDURE** Station personnel appropriately responded to PECO management expectations to improve performance and reduce the number of events due to inadequate procedures. A residual heat removal logic system functional test was appropriately postponed to evaluate a technical adequacy concern identified by a work control supervisor.
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07/14/1999	1999301	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**LIMITED SENIOR REACTOR OPERATOR INITIAL EXAMS** Six Limited Senior Reactor Operator (LSRO) applicants were administered initial licensing exams. All applicants successfully passed all portions of the exam.
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06/28/1999	1999005	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** 3A **Ter:**	**OPERATOR RESPONSE TO OFF-NORMAL CONDITIONS** Operators took prompt and effective actions in response to three off-normal conditions during the period: 1) a loss of power to the Unit 3 primary feedwater control computer, 2) a Unit 2 plant monitoring system computer interruption, and 3) a Unit 3 reactor core isolation cooling system high suction pressure alarm. Appropriate follow-up actions were completed or planned by station personnel.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
06/28/1999	1999005	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 5A **Ter:**	**NUCLEAR QUALITY ASSURANCE ASSESSMENT OF PLANT OPERATION ACTIVITIES** During March through April 1999, Nuclear Quality Assurance (NQA) performed a thorough assessment of Plant Operations Activities. The assessment was comprehensive and provided several insights into current operations performance. The most significant NQA assessment finding was the identification of an adverse trend in the effectiveness of corrective actions to preclude repetition of some deficiencies.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
06/28/1999	1999005-01	**Pri:** OPS **Sec:**	Self	NCV	**Pri:** 1C **Sec:** 3A **Ter:** 5B	**INADVERTENT LOSS OF THE 3 EMERGENCY AUXILIARY TRANSFORMER DURING 343 START-UP BUS RESTOF** On May 21, 1999, unplanned engineered safety feature actuations occurred on both units due to the de-energization of the Unit 3 emergency auxiliary transformer during restoration of the 343 startup bus to the normal offsite power supply. The investigation for this event was excellent and provided detailed insights into its causes. The root cause of this event was unclear management expectations for controlling equipment configuration status. The lack of adequate written instructions for equipment status control resulted in a Severity Level IV violation that was treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This item is documented in PECO's corrective action program as PEP I0009864.
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05/17/1999	1999004	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** 1A **Ter:**	**OPERATIONS PERSONNEL RESPONSE TO HIGH CONTROL ROD DRIVE (CRD) SEAL TEMPERATURES** Inspectors identified two discrepancies during the review of a high temperature condition (above 500 F) on a Unit 3 control rod drive (CRD). The station had not incorporated into operating response procedures the practice of moving a CRD from the full out position to correct a high temperature condition. In addition, operators were not documenting in the CRD discrepancy log that a CRD was moved to reduce the temperature.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
05/17/1999	1999004	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 3A **Ter:**	**EQUIPMENT OPERATOR (EO) PERFORMANCE DURING DAILY ROUNDS** Equipment operators performed well during plant rounds. They properly completed surveillance readings and reported abnormal plant conditions. The use of peer mentors for improving performance of newly qualified equipment operators was a positive practice.
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05/17/1999	1999004	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**SITE USE OF OVERTIME** PECO controlled the overtime hours of operations and maintenance personnel within the limits of the technical specifications and administrative procedures.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
04/05/1999	1999002	**Pri:** OPS **Sec:**	Self	NEG	**Pri:** 1C **Sec:** 1A **Ter:**	**REACTOR CORE ISOLATION COOLING (RCIC) ISOLATION DURING SYSTEM RESTORATION** An unexpected engineered safety feature system isolation occurred during restoration of the Unit 3 reactor core isolation cooling (RCIC) system. As the reactor operator opened the RCIC outboard isolation valve during re-pressurization of the system, RCIC isolated due to a high steam flow condition. Non-specific procedural guidance regarding the opening methodology for the RCIC outboard isolation valve was a contributing cause.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
04/05/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** 1C **Ter:**	**ANNUAL LICENSED OPERATOR REQUALIFICATION EXAMINATIONS** The performance of two crews observed during the annual licensed operator examination was good in the areas of event recognition and diagnosis, control board manipulations, technical specification usage, and event classification. Improvements were noted, from the 1998 requalificaiton examination observations, in the conduct of crew briefs and the use of three part communications.
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02/15/1999	1999001	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 5A **Sec:** 5C **Ter:** 1C	**CORRECTIVE ACTION SYSTEM REVIEW** Station corrective action processes were effective in identifying and resolving significant conditions adverse to quality. Problem identification was good for significant issues under the Performance Enhancement Program (PEP) process, but inconsistencies were noted in the identification and reporting of lower-level issues under lower tier reporting systems. Most investigations were thorough and completed in a timely manner. Problem solution was generally effective. However, inspectors noted a backlog of corrective action items awaiting reviews for adequacy. Station management stated that they had recognized some shortcomings in the corrective action processes and had begun improvement initiatives.
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02/15/1999	1999001	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 5A **Sec:** **Ter:**	**NUCLEAR REVIEW BOARD MEETING** The Nuclear Review Board provided good independent discussion and evaluations of the topics presented during the February 4, 1999 meeting. The questions directed to the presenters by the members of the Board during this meeting were probing and insightful. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3
12/27/1999	1999009-02	**Pri:** MAINT **Sec:**	Licensee	NCV	**Pri:** 2B **Sec:** 3A **Ter:**	**DEFICIENCIES IN TESTING AND CALIBRATION PROCEDURES THAT RESULTED IN UNEXPECTED PLANT SYSTE** A full scram signal and a Group 1 isolation signal occurred while Unit 3 was in the refueling mode due to an inadequate surveillance test procedure. Station personnel performed an investigation into this event and provided comprehensive corrective actions to address identified deficiencies. The investigation identified concerns with the station's change management process for groups assuming new tasks. Operations personnel demonstrated a good questioning attitude by identifying a test procedure inadequacy that had rendered all four residual heat removal pumps inoperable for a period of approximately two hours during testing prior to 1998. The above two examples of inadequate procedures are being treated as a Non-Cited Violation (NCV) consistent with Section VII.B.1.a of the NRC Enforcement Policy. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3
11/08/1999	1999008	**Pri:** MAINT **Sec:**	Self	NEG	**Pri:** 3A **Sec:** 3C **Ter:**	**MAIN CONTROL ROOM MODIFICATION MAINTENANCE CAUSES REACTOR PROTECTION SYSTEM ACTUATION** Poor work practices by maintenance personnel performing modifications on control room panels in preparation for the Unit 3 refueling outage caused two engineered safety feature actuations. The corrective actions taken for each event were adequate. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3
09/20/1999	1999007	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 2B **Sec:** 2A **Ter:** 4B	**UNIT 3 REACTOR WATER CLEANUP (RWCU) MAINTENANCE OUTAGE** During a planned replacement of the Unit 3B reactor water cleanup system pump discharge check valve, the radiation dose received by workers exceeded the initial estimate due to poor initial planning and poor communication between work groups. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3
09/20/1999	1999007	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3C **Sec:** 3B **Ter:**	**E2 EMERGENCY DIESEL GENERATOR (EDG) COOLANT EXPANSION TANK PARTIALLY DRAINED AFTER CONTF** A contract cleaning worker inadvertently bumped a jacket water coolant drain valve for the E2 emergency diesel generator, resulting in a partial drain down of the coolant expansion tank and an alarm in the control room. The emergency diesel generator was not rendered inoperable. Poor awareness by contract cleaning personnel of the potential for repositioning valves on the emergency diesel generator skid during cleaning operations contributed to this problem. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3

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09/20/1999	1999007	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 5A **Sec:** 3A **Ter:**	**UNIT 3 NEW FUEL RECEIPT INSPECTION ACTIVITIES** The nuclear maintenance technicians effectively inspected new fuel for the upcoming Unit 3 outage. They identified a bent lower tie plate spacer and several pieces of foreign material. PECO took appropriate corrective actions.
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09/20/1999	3-99-005-00	**Pri:** MAINT **Sec:**	Licensee	LER	**Pri:** 4A **Sec:** **Ter:**	**UNPLANNED ENGINEERED SAFETY FEATURE (ESF) ACTUATIONS DURING PLANNED MODIFICATION ACTIVITIE** ON 9/20/99, AN ELECTRICIAN (VENDOR) WAS INSTALLING A NEW MOUNTING PLATE ON A MAIN CONTROL ROOM PANEL TO ALLOW REORIENTATION OF THE WIDE RANGE NEUTRON MONITORING SYSTEM (WRNMS) INDICATOR. THE WRNMS INDICATOR WAS REQUIRED TO BE RE-ORIENTED AS PART OF THE POWER RANGE NEUTRON MONITORING SYSTEM (PRNMS) INSTALLATION. THE MOUNTING PLATE REQUIRED SEVERAL EXISTING HOLES TO BE ENLARGED AND SEVERAL NEW HOLES TO BE DRILLED INTO THE PANEL TO ALLOW INSTALLATION OF THE WRNMS INDICATOR. WHILE ATTEMPTING TO ENLARGE ONE OF THE EXISTING HOLES IN THE PANEL, THE DRILL BIT CAUGHT A FOREIGN MATERIAL EXCLUSION (FME) BAG WHICH WAS STAGED AS PART OF THE MODIFICATION WORK. THIS RESULTED IN THE 3 'B' RPS WIRE WAS SHORTED TO GROUND WHEN THE CONDUCTOR WAS NICKED BY THE DRILL BIT. THIS RESULTED IN A BLOWN FUSE IN THE RPS LOGIC. A MANUAL HALF SCRAM OCCURRED AND THE OUTBOARD SDV VENT AND DRAIN VALVES CLOSED. THE RPS WIRE WAS REPAIRED, THE FUSE WAS REPLACE, THE 'B' CHANNEL RPS MANUAL HALF SCRAM WAS RESET AND THE SDV VENT AND DRAIN VALVES WERE REOPENED.
Dockets Discussed: 05000278 Peach Bottom 3						
08/09/1999	1999006	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 2A **Ter:**	**FAILURE OF THE 2B AND 3F AVERAGE POWER RANGE MONITORS** Station personnel took reasonable actions to address failures of the 2B and 3F average power range monitors (APRMs). Instrument and control technicians satisfactorily performed APRM post-maintenance testing. Technicians demonstrated good work practices by stopping APRM testing to obtain a temporary change to the procedure when the guidance in a surveillance instruction was unclear.
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08/09/1999	1999006	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 3B **Ter:**	**CONDUCT OF MAINTENANCE** Instrument and control (I&C) technicians actively used procedures and exhibited very good communications, self-checking, and peer checking during the performance of work and surveillance activities.
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06/28/1999	1999005	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**SAFE SHUTDOWN EMERGENCY LIGHTING REVIEW** Required station emergency lighting units were tested and inspected according to plant procedures and consistent with Appendix R requirements. Corrective maintenance was performed promptly. Maintenance action requests were not being reviewed for maintenance rule implications due to an action request database error that indicated the lighting units were not within the scope of the rule. This deficiency was entered into the corrective action program and corrected.
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06/28/1999	1999005	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** 3B **Ter:**	**EQUIPMENT STATUS CONTROL ISSUE ASSOCIATED WITH INSTRUMENTATION & CONTROLS WORK** During post maintenance testing, Instrumentation and Controls (I&C) technicians identified that they had not properly restored a core spray system flow transmitter to service following maintenance. Overall the PECO investigation and corrective actions for this event were appropriate and identified that incorrect assumptions were made regarding restoration instructions and some actions stated in the clearance and tagging manual were not performed.
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05/17/1999	1999004	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**THERMOLAG REMEDIATION WORK** Maintenance activities associated with Thermolag and penetration seal upgrades were typically well-controlled.
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04/05/1999	1999002	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 3B **Sec:** 2A **Ter:**	**E-3 EMERGENCY DIESEL GENERATOR (EDG) SCHEDULED MAINTENANCE OUTAGE** Although the E-3 emergency diesel generator 24 month overhaul maintenance outage was generally well planned, unexpected coolant water jacket leaks and a speed relay failure significantly extended the emergency diesel generator outage length. In anticipation of exceeding the technical specification (TS) limiting condition for operation (LCO) for the length of time an emergency diesel generator can be out of service, PECO staff requested the NRC to grant enforcement discretion and extend the out of service time by three days. Since PECO staff returned the emergency diesel generator to service within the TS LCO time, the NRC did not need to grant the enforcement discretion.
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05/06/1999	1999002-01	**Pri:** MAINT **Sec:**	Licensee	NCV	**Pri:** 2A **Sec:** **Ter:**	**INOPERABILITY OF BOTH CHANNELS OF THE UNIT 2 ROD BLOCK MONITOR DUE TO A LOCAL POWER RANGE** A wiring error dating back to original construction was discovered which resulted in non-conservative inputs to both channels of the Unit 2 rod block monitor for 29 of 185 control rods. A thorough root-cause analysis was performed for this event and corrective actions were comprehensive. In accordance with the NRC Enforcement Policy, Section VII.B.3, Violations Involving Old Design Issues, the NRC is exercising enforcement discretion and not citing this violation. (NCV 50-277/99-02-01)
Dockets Discussed: 05000277 Peach Bottom 2						
02/15/1999	1999001	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** 3A **Ter:**	**Unit 3 HPCI Scheduled Maintenance Outage** The Unit 3 High Pressure Coolant Injection (HPCI) on-line outage work was well planned with an effective post-maintenance test. Although the station returned the HPCI system to an operable status within technical specification requirements, problems with the gland seal condensate pump resulted in the HPCI outage being extended past the original schedule.
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02/15/1999	1999001	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** 1C **Ter:**	**Use of PRA Techniques During Plant Work Activities** The station has effectively incorporated the probabilistic risk assessment individual plant evaluations for core damage frequency and large early release frequency into the planning of system outages and assessment of plant risk due to emergent work.
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12/27/1999	1999009	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** 5A **Ter:**	**FAILURE OF THE UNIT 2 HPCI STEAM ADMISSION MOTOR-OPERATED VALVE (MOV) (MO-14) TO OPEN** Although PECO engineering was aware that the Unit 2 high pressure coolant injection (HPCI) steam admission valve could fail to open because of thermal binding when the system was isolated for maintenance, engineering personnel failed to prevent this type of failure during maintenance performed on November 2, 1999. This resulted in a minor increase in system unavailability.
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12/27/1999	1999009	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 5A **Ter:**	**INDEPENDENT SPENT FUEL STORAGE INSTALLATION** The planning, fabrication and documentation for the TN-68 dry fuel storage casks at Precision Components Corporation met the design configuration. Effective fabrication practices were in use and extensive Quality Assurance coverage by PECO Nuclear was in place at the manufacturing plant.
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11/08/1999	1999008	**Pri:** ENG **Sec:**	Self	NEG	**Pri:** 2A **Sec:** 5A **Ter:**	**LOSS OF POWER TO THE TECHNICAL SUPPORT CENTER AND RELIABILITY OF THE 351 POWER LINE** Engineering personnel identified a reliability problem with the 351 and SBO power lines from Conowingo Dam, the normal and alternate power supply to the Unit 1 load center and technical support center (TSC). Repeated storm damage events caused a loss of power to the TSC, resulting in loss of emergency assessment capability and NRC notifications. The inspectors noted that PECO has action in progress that is designed to improve reliability.
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11/08/1999	1999008	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4A **Sec:** 3A **Ter:**	**RECIRCULATION LOOP FLOW INSTRUMENTATION MODIFICATION** An engineering modification error caused the flow indication for the 3A recirculation loop to be displayed on the wrong indicator. This event was of minimal consequence, but it revealed several personnel performance deficiencies related to insufficient design reviews, an incomplete acceptance test procedure, and non-adherence to engineering department procedures and guidance.
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11/08/1999	1999008	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 4C **Ter:**	**INSERVICE INSPECTION (ISI)** Inservice inspection was performed acceptably and included appropriate ASME program coverage, qualified personnel, approved procedures, proper implementation, acceptable examination documentation and PECO oversight. The inspections performed were thorough and of sufficient extent to determine the integrity of the components inspected.
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11/08/1999	1999008	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4A **Sec:** 3A **Ter:**	**PLANT DESIGN CHANGE REVIEWS** The design changes regarding the vital bus under-voltage relay replacement were properly designed and implemented. The affected design basis documents were appropriately updated or identified for future update. The critical characteristic valuation for the new relays and post modification testing were appropriately completed.
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11/08/1999	1999008-02	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 3A **Sec:** 4C **Ter:**	**INSERVICE INSPECTION (ISI)** The failure to adhere to procedural requirements in the performance of ultrasonic testing of safety-related components was identified by the inspectors and is a violation of NRC requirements. This violation is identified as a non-cited violation (NCV) in accordance with Section VII.B.1.a to the NRC Enforcement Policy. The violation was placed the licensee's corrective action program as PEP I0010349.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
11/08/1999	1999008-03	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4C **Sec:** 3A **Ter:**	**INSERVICE INSPECTION (ISI)** The failure to include two core spray system welds in the ISI program plan was an violation of 10 CFR 50.55a(g)(3), "Inservice Inspection Requirements. This violation is identified as a non-cited violation (NCV) in accordance with Section VII.B.1.a to the NRC Enforcement Policy. The violation was placed the licensee's corrective action program as PEP I0010372.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
09/20/1999	1999007	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** 1B **Ter:**	**SHUTDOWN OF THE UNIT 2 RECIRCULATION PUMPS DUE TO FOULING ON SERVICE WATER SIDE OF THE MO** During preparations for Tropical Storm Floyd, engineering personnel did not highlight to the station the degraded conditions that existed on the Unit 2 recirculation pump motor generator lube oil coolers or the need for contingency plans should their performance further degrade. Further degradation in the Unit 2 recirculation pumps motor generator lube oil coolers occurred in the aftermath of the storm, which resulted in significant challenges for station personnel, especially Operations.
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09/20/1999	1999007	**Pri:** ENG **Sec:**	Licensee	NEG	**Pri:** 4C **Sec:** 5A **Ter:**	**DISCREPANCIES WITH TESTING OF THE 'A' EMERGENCY SERVICE WATER (ESW) PUMP** Engineering personnel did not recognize the importance of maintaining the instrumentation constant during inservice testing for the A emergency service water (ESW) pump. This resulted in the repeat performance of a surveillance test which causes long term, pump degradation due to low flow testing conditions.
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08/09/1999	1999006	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 5B **Sec:** 5A **Ter:** 4B	**FAILURE OF MO-2-10-089A RESIDUAL HEAT REMOVAL (RHR) HIGH PRESSURE SERVICE WATER (HPSW) HEAT** PECO took effective action to restore the function of the Unit 2 residual heat removal high pressure service water heat exchanger outlet valve after it failed to open during testing due to an auxiliary contact failure. Site engineering initiated a full root cause analysis to investigate the numerous auxiliary contact failures that have occurred over the last three years. Nevertheless, engineering personnel were slow in recognizing the pattern of these failures.
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08/09/1999	1999006	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** 5A **Ter:**	**EMERGENCY SERVICE WATER SYSTEM FLOW DEGRADATION** Engineering personnel demonstrated good support of plant operations through their review of a trend in emergency service water flow rate. Engineers noted that flow rates through some emergency core cooling water system room coolers were trending downward, and they made prompt recommendations to clean the coolers before system operability was challenged.
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09/01/1999	3-99-004-00	**Pri:** ENG **Sec:**	Licensee	LER	**Pri:** 3A **Sec:** **Ter:**	**MULTIPLE UNPLANNED ENGINEERED SAFETY FEATURE (ESF) ACTUATIONS DURING PLANNED MODIFICATIOI** ON WEDNESDAY, SEPTEMBER 1, 1999 AT APPROX. 0850 HOURS, DURING PLANNED MODIFICATION ACTIVITIES ON A MAIN CONTROL ROOM PANEL, THE 3A REACTOR PROTECTION SYSTEM (RPS) BUS WAS INADVERTENTLY DEENERGIZED. AN ELECTRICIAN INADVERTENTLY REPOSITIONED THE RPS ALTERNATE POWER TRANSFER SWITCH WHICH CAUSED THE DEENERGIZATION OF THE 3A RPS BUS. THIS CAUSED THE INBOARD PCIS GROUP III ISOLATION VALVES TO CLOSE AND INITIATED THE UNIT 3 STANDBY GAS TREATMENT (SGT) SYSTEM. THIS CONSTITUTED AN UNPLANNED ENGINEERING SAFETY FEATURE (ESF) ACTUATION AND RESULTED IN A NON-EMERGENCY FOUR HOUR NOTIFICATION TO THE NRC PER 10 CFR 50.72(b)(2) (ii). THE OPERATING CREW RESPONDED TO THE LOSS OF POWER TO THE 3A RPS BUS PER APPROPRIATE PLANT PROCEDURES AND RESTORED ALL PCIS GROUP III ISOLATION VALVES SYTEMS AND SGT SYSTEM TO THEIR NORMAL CONFIGURATIONS. THIS CONDITION IS REPORTABLE PER 10 CFR 50.72(a)(2)(iv).
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06/28/1999	1999005-02	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4A **Sec:** 5A **Ter:**	**FIRE PROTECTION PLAN NON-CONFORMANCES (UNITS 2 AND 3)** During the past nine months, PECO engineering personnel have identified several subtle, historical non-conformances to the Peach Bottom Fire Protection Plan during their reviews of the fire protection program. These reviews have been notably comprehensive with appropriate corrective actions taken for deficiencies identified. The non-conformances with the Fire Protection Plan constituted a Severity Level IV violation that was treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. These non-conformances are documented in PECO's corrective action program as PEPs I0009023, I0009584, and I0009737. (EA 99-192)
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
05/06/1999	1999002	**Pri:** ENG **Sec:**	Licensee	NEG	**Pri:** 4B **Sec:** 3A **Ter:**	**LOCKUP OF UNIT 2 PLANT MONITORING SYSTEM COMPUTERS DURING COMPUTER TESTING** Unit 2 plant monitoring system computers locked-up during testing, because an information systems engineer did not adhere to station policy regarding stopping of testing when unexpected conditions occur. The station's root cause analysis and planned corrective actions were comprehensive. This event did not constitute a violation of NRC requirements.
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04/05/1999	1999002	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** 3A **Ter:**	**GENERAL COMMENTS** The inspectors noted several cases where errors by engineering department personnel resulted in challenges to plant systems or components related to motor operated valve calculations, investigation of the 3 B core spray breaker failure, computer testing and a Unit 2 electro-hydraulic control system modification.
Dockets Discussed: 05000277 Peach Bottom 2 05000278 Peach Bottom 3						
02/15/1999	1999001	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** 5A **Ter:**	**Motor-Operated Valve Problem** In five instances, nonconformance report dispositions for motor-operated valve (MOV) anomalies were narrowly focused. Although operability determinations for the valves were acceptable, the causes of the anomalus conditions, such as lubrication degradation, were not adressed or evaluated for corrective action. PECO was implementing corrective actions to address MOV program deficiencies.
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02/15/1999	1999001	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4C **Sec:** 5C **Ter:**	**Limitorque Technical Update 98-01 for AC Motor-Operated Valves** PECO performed a comprehensive assessment of new information regarding motor-operated valve (MOV) output capability contained in Limitorque Technical Update 98-01. Operability determinations used best available industry data for calculating motor actuator performance capabilities and used reasonable technical assumptions. Planned long-term corrective actions appropriately addressed restoration of MOV design margins. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3
02/15/1999	1999001-01	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4B **Sec:** 5A **Ter:**	**HPCI System Gland Seal Condenser Leak (Unit 2)** A significant leak on the Unit 2 High Pressure Coolant Injection (HPCI) system gland seal condenser was caused by an inadequate maintenance procedure. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as PEP I0009358. Engineering troubleshooting and investigation efforts following the significant leak on the Unit 2 high pressure coolant injection system gland seal condenser resulted in effective corrective actions. However, operations and engineering had missed opportunities, prior to the leak, to identify the cause of the abnormal high pressure coolant injection system reponse. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3
12/27/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 5B **Sec:** 5C **Ter:**	**HIGHER THAN EXPECTED RADIATION LEVELS DURING REACTOR CAVITY DRAIN-DOWN** Higher than expected radiation levels in the reactor cavity were caused by placing newly discharged fuel in close proximity to the spent fuel pool gates. Station personnel performed a thorough investigation into this issue and initiated corrective actions designed to prevent recurrence. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3
11/08/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 2A **Ter:** 3A	**CONDUCT OF SECURITY AND SAFEGUARDS ACTIVITIES** Security and safeguards activities were conducted in a manner that protected public health and safety. Protected area assessment aids, protected area detection aids, and personnel search equipment were well maintained. Security and safeguards procedures were properly implemented. The security force members (SFMs) demonstrated that they had the requisite knowledge necessary to effectively implement their duties. Management support was adequate to ensure effective implementation of the security program. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3
11/08/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**UNIT 3 REFUELING OUTAGE RADIOLOGICAL CONTROLS (ALARA) PLANNING AND PERFORMANCE** Overall, PECO implemented an effective ALARA program. PECO met its 1999 outage ALARA goals and implemented good efforts to reduce personnel occupational exposure for work activities to as low as is reasonably achievable. **Dockets Discussed:** 05000277 Peach Bottom 2 05000278 Peach Bottom 3

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11/08/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**UNIT 3 REFUELING OUTAGE RADIOLOCAL CONTROLS (INTERNAL AND EXTERNAL EXPOSURE CONTROLS)** Applied radiological controls for ongoing work activities were generally well implemented. Overall, PECO implemented an effective radioactive material and contamination control program. PECO implemented effective assessments of ongoing radiological controls activities. The assessments were of good scope and depth and were performance based.
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09/20/1999	1999007	**Pri:** PLTSUP **Sec:**	Licensee	POS	**Pri:** 3A **Sec:** **Ter:**	**UNEXPECTED LOSS OF PART OF THE PROTECTED AREA SECURITY LIGHTING** Around sunset on September 5, 1999, a site security guard noticed that some of the perimeter security lighting near the warehouse building was off. Site security personnel immediately implemented compensatory actions for the loss of lighting until the lighting was restored. The security guard exhibited excellent questioning attitude and awareness of security equipment conditions by identifying the perimeter lighting that was off at dusk.
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06/28/1999	1999005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:** 3B	**RADIOACTIVE WASTE SOURCES AND PROCESSING SYSTEMS, RADIONUCLIDE SCALING FACTORS, WASTE C** PECO implemented effective programs in the areas of radioactive waste source evaluation, processing and handling, determination of radionuclide scaling factors, waste classification, and volume reduction efforts. PECO developed appropriate scaling factors for hard to detect radionuclides, performed appropriate radionuclide concentration averaging, and implemented waste volume reductions efforts.
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06/28/1999	1999005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**PERSONNEL DIVING IN UNIT 2 SPENT FUEL POOL** PECO thoroughly planned for the personnel diving in the Unit 2 spent fuel pool. The diving evolutions were carefully monitored by health physics personnel. PECO's excellent dose reduction efforts resulted in significantly lower than expected overall dose to the divers.
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06/28/1999	1999005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 1C **Ter:**	**RADIOACTIVE MATERIAL TRANSPORTATION ACTIVITIES** PECO implemented an effective radioactive waste and radioactive material packaging and shipping program and successfully shipped irradiated hardware and clean-up filters from its Unit 3 spent fuel storage pool.
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05/17/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 2A **Ter:**	**READINESS OF SITE EMERGENCY RESPONSE FACILITIES** Communications equipment, supplies and data acquisition systems were maintained in a high state of operational readiness in the Technical Support Center and the Operational Support Center. Emergency siren activation equipment was fully operational. Equipment and supplies for off-site dose assessment teams were properly calibrated and fully functional.
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05/17/1999	1999004-01	**Pri:** PLTSUP **Sec:**	Licensee	NCV	**Pri:** 3A **Sec:** 1C **Ter:**	**INADVERTENT DISABLING OF A UNIT 3 SAFEGUARD SYSTEM VITAL AREA DOOR** On April 6, 1999, site security personnel discovered that a Unit 3 vital area door alarm had been disabled. The alarm had inadvertently been disabled by security personnel during planned maintenance on security system equipment. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This item is in PECO's corrective action program as PEP I0009658.
Dockets Discussed: 05000278 Peach Bottom 3						
04/05/1999	1999002	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 2B **Ter:**	**RADIOLOGICAL CONTROLS-RADIOACTIVE MATERIALS, CONTAMINATION, SURVEYS, AND MONITORING** The staff effectively controlled activities in radiological controlled areas. Health Physics technicians performed proper surveys and properly documented survey results. Radiological housekeeping conditions were noted to be good. The number and type of personnel contaminations were tracked, trended, and evaluated for cause and corrective actions. The radiological surveys, monitoring, and controls were implemented with properly calibrated devices.
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04/05/1999	1999002	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 2B **Sec:** **Ter:**	**RADIOLOGICAL CONTROLS-AS LOW AS REASONABLY ACHIEVABLE (ALARA)** PECO implemented an effective program to maintain occupational radiation exposure as low as is reasonably achievable (ALARA), and the ALARA efforts and results for 1998 were good, including the management of radiologically significant outage work.
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04/05/1999	1999002	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 5A **Sec:** 5C **Ter:** 5B	**QUALITY ASSURANCE IN RP&C ACTIVITIES** PECO's self-identification and corrective action processes in the area of radiation protection were effective. Nuclear Quality Assurance surveillance reports, self-assessments, and the corrective action program continued to be effective in identifying, at a low threshold, deficiencies and improvement opportunities. Effective corrective actions were implemented when discrepancies were identified.
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02/15/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** 3C **Ter:**	**Removal of Contaminated Filters from the Unit 3 Spent Fuel Pool** Generally, movement of the contaminated filters from the spent fuel pool to the shipping cask was performed well with good radiation technician monitoring and oversight and good ALARA awareness and actions by the workers. The inspector observed a slow response to an area radiation monitor alarm.
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02/15/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**Status of Security Facilities and Equipment** Security facilities and equipment were determined to be well maintained and reliable. Security procedures were being properly implemented. Security staff knowledge, performance and training were determined to be acceptable. Security organization and administration were adequate to ensure effective implementation of the program.
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Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.