

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I

BEAVER VALLEY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/08/2000	1999010	Pri: OPS Sec:	NRC	NEG	Pri: 5A Sec: 3A Ter: 1A	UNTIMELY IDENTIFICATION OF A WATER HAMMER EVENT Untimely identification of a water hammer event permitted an unanalyzed Unit 2 plant configuration (two inoperable service water pumps) to exist for several days. Neither the outside tour operator, nor the work control center senior reactor operator recognized that a damaged service water pump discharge pressure gage may be an indicator of a water hammer event.
Dockets Discussed: 05000412 Beaver Valley 2						
01/08/2000	1999010	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 4B Ter: 2A	PROCEDURES FOR COLD WEATHER PREPARATION WERE PROPERLY PERFORMED Procedures for cold weather preparations were properly performed. Operations, engineering, and maintenance personnel communicated well to appropriately prioritize repairs of degraded cold weather protection equipment. Compensatory measures were properly applied for the instances where repairs were not completed prior to the onset of freezing temperatures. Overall material readiness for cold weather was good.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
01/08/2000	1999010	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: 3A Ter:	LICENSED OPERATOR REQUALIFICATION TRAINING PROGRAM The Licensed Operator Requalification Training program content was balanced and met the needs of the operators. The facility presented appropriate, well-prepared training both in the classroom and simulator. The feedback process, as part of the systems approach to training program, was effective. Selected industry events, which were applicable to Beaver Valley's operators, were properly incorporated into the training.
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01/08/2000	1999010	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: 5C Ter:	EMPLOYEE CONCERN PROGRAM The employee concern program provided an effective means for concerned individuals to raise safety issues and receive feedback concerning how their issues were resolved.
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01/08/2000	1999010	Pri: OPS Sec: ENG	NRC	POS	Pri: 1C Sec: 4B Ter: 3A	YEAR 2000 ROLLOVER Station personnel and equipment systems were properly prepared for the Year 2000 (Y2K) computer rollover. Monitoring and contingency plans were comprehensive and were effectively implemented. Industry experience was monitored during the Y2K rollover and promptly communicated to the control room staff.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
01/08/2000	1999010-01	Pri: OPS Sec:	NRC	IFI	Pri: 1C Sec: Ter:	POTENTIAL FOR LICENSED OPERATION REQUALIFICATION EXAM SECURITY COMPROMISE Written and operating exam content met regulatory requirements; however, two deficiencies were noted. The process for administering the annual/biannual requalification exams has a potential for exam security compromise (Condition Report 993236). Also, licensed operators were evaluated as a crew during simulator scenario exercises, rather than receiving formal individual evaluations, unless they fail to perform a critical task (Condition Report 993235). In addition, the inspectors noted that evaluation techniques had the potential for bias.
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11/27/1999	1999009	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: 3A Ter: 3B	A Unit 2 operating crew failed to recognize the technical specification applicability when the crew discovered A Unit 2 operating crew failed to recognize the technical specification applicability when the crew discovered the onsite to offsite 4 kilovolt auto bus transfer feature disabled. This demonstrated a weakness in questioning attitude and knowledge associated with technical specifications.
Dockets Discussed: 05000412 Beaver Valley 2						
11/27/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 3A Ter: 2A	The decision to shut down Unit 2 to repair leaking pressurizer relief and safety valves was appropriate. The decision to shut down Unit 2 to repair leaking pressurizer relief and safety valves was appropriate. The plant shutdown and restart were performed in a safe and controlled manner. Operations management and quality services unit personnel provided close oversight. Pre-evolution briefings for the Unit 2 plant depressurization as well as the Unit 1 downpower to replace a main turbine electro-hydraulic control system power supply were comprehensive and contributed to safely conducted operations.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
11/27/1999	1999009	Pri: OPS Sec: ENG	NRC	POS	Pri: 5B Sec: 5C Ter: 1C	Station personnel effectively evaluated and safely resolved several material problems affecting steam genera Station personnel effectively evaluated and safely resolved several material problems affecting steam generator chemistry, reactor coolant system leakage, and fire protection. The degraded conditions were properly identified, action plans and objectives were clearly communicated, and the results were closely monitored. The one-stop-shop closely managed work activities, reduced potential operator distractions, and clearly communicated job status with the control room staff during two plant outages. This communication facilitated good plant configuration control and plant safety.
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11/27/1999	1999009-01	Pri: OPS Sec:	NRC	NCV	Pri: 3A Sec: 3C Ter: 1A	Failure to Verify Off-Site Power Alignment Technical Specificaiton 4.8.1.1.1.a An operator error resulted in failure to restore auto bus transfer capability from onsite power to one of the two Unit 2 offsite 4 kilovolt power supplies. Contributing causes included poor procedure quality, method of procedure usage, and worker fatigue. Although this event was not directly attributed to fatigue, management of overtime, especially for operators (24 to 37 percent overtime) continued to be a challenge. Violation of Technical Specification 4.8.1.1.1.a. Enforcement Discretion per Section VII.B.1.a of the NRC Enforcement Policy. See Condition Report 992763.
Dockets Discussed: 05000412 Beaver Valley 2						
10/16/1999	1999008	Pri: OPS Sec:	Licensee	POS	Pri: 1A Sec: 3A Ter: 2A	On September 12, operators promptly established a reliable 4kV bus electrical lineup. On September 12, operators promptly established a reliable 4kV bus electrical lineup after identifying a failure of one of the onsite 4kV supply breakers. Good observation by a plant operator prevented a similar failure of the off-site 4kV supply breaker.
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10/16/1999	1999008	Pri: OPS Sec:	Self	POS	Pri: 1B Sec: 3A Ter: 2A	On September 6, control room operators promptly responded to failed main unit generator indications On September 6, control room operators promptly responded to failed main unit generator indications and placed the plant in a safe shutdown condition. The Operations Manager made a good decision to perform additional generator troubleshooting with the reactor in a shutdown condition. The reactor startup and generator synchronization procedures were briefed in detail and properly controlled. Control room communications, and management and Quality Assurance oversight were good. Reference LER 50-334/99-10.
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10/16/1999	1999008	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: 5C Ter:	Corrective actions to a technical specification violation included a reduction in the number of outstanding operations. Corrective actions to a technical specification violation included a reduction in the number of outstanding operations manual change notices from 670 to 30.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
08/27/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 3A Sec: 5B Ter:	Review of the Offsite Review Committee and Nuclear Safety Review Board Review of the Offsite Review Committee and Nuclear Safety Review Board indicated that they were effectively implementing their charters, properly reviewing and commenting on plant issues and events, and appropriately documenting their findings and recommendations.
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08/27/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 3C Sec: 3A Ter: 5A	Quality Services Unit audits were of sufficient scope and depth Quality Services Unit audits were of sufficient scope and depth to properly identify programmatic deficiencies and weaknesses. Quality Services Unit's new program to evaluate self-assessments was a good initiative to improve quality and consistency.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
08/27/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 5A Sec: 5C Ter:	The operations department has increased and improved its ability to identify problems. The operations department has increased and improved its ability to identify problems through the Condition Report program and self-assessments. The Condition Report System has been effective in addressing issues placed into it.
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09/04/1999	1999005	Pri: OPS Sec:	NRC	POS	Pri: 4B Sec: 2A Ter: 1A	The licensee eliminated a Unit 1 risk significant workaround The licensee eliminated a Unit 2 risk significant workaround associated with maintaining control rods in manual control. The cumulative impact of the operator workarounds was minimal.
Dockets Discussed: 05000412 Beaver Valley 2						
09/04/1999	1999005-01	Pri: OPS Sec:	NRC	NCV	Pri: 1A Sec: 3A Ter:	Improper Operator Troubleshooting In two separate instances, valves were manipulated contrary to controls implemented previously for configuration control and troubleshooting. No adverse safety consequences resulted from the actions. Violation of Technical Specification 6.8.1; Enforcement Discretion per Appendix C of the NRC Enforcement Policy. See Condition Report 991896.
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/29/1999	1999007	Pri: OPS Sec:	NRC	NEG	Pri: 4B Sec: 3A Ter: 5A	The licensee's 1997 Probability Risk Assessment shows reactor coolant pump seal failures The licensee's 1997 Probability Risk Assessment shows that reactor coolant pump seal failures contribute 50% of the total core damage frequency for BV Unit 2. This risk insight was not previously used to identify improvements in plant procedures, operator training, or control room alarm human-factors that would assist with mitigation of this risk significant event.
Dockets Discussed: 05000412 Beaver Valley 2						
07/29/1999	1999007-01	Pri: OPS Sec:	NRC	NCV	Pri: 1B Sec: 3A Ter: 5A	The Beaver Valley Unit 2 Operating crew failed to recognize that all seal cooling for two RCPs was lost The BV Unit 2 operating crew failed to recognize that all seal cooling for two RCPs was lost and consequently, they did not implement actions specified in an alarm response procedure to protect the seals. The importance of these actions was not emphasized in training or indicated by the human factoring of the control room annunciators. The failure to implement this procedure is a violation of TS 6.8.1, which has been entered in the licensee's corrective action program and is being treated as a non-cited violation consistent with the NRC Enforcement Policy.
Dockets Discussed: 05000412 Beaver Valley 2						
07/29/1999	1999007-02	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: 5C Ter: 3A	The licensee failed to develop procedures for loss of emergency power The licensee failed to develop procedures for loss of emergency power, as required by Regulatory Guide 1.33 and the Technical Specifications. Although Operations department personnel knew procedure guidance was lacking in this area, the "loss of bus" procedure had not been identified as a required procedure. This violation of TS 6.8.1, has been entered in the licensee's corrective action program and is being treated as a non-cited violation consistent with the NRC Enforcement Policy.
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07/24/1999	1999004	Pri: OPS Sec:	NRC	NEG	Pri: 3A Sec: 1A Ter: 3B	Operations management did not take timely action to ensure two problems associated with the July 18 Unit 2 Operations management did not take timely action to ensure two problems associated with the July 18 Unit 2 forced shutdown, were addressed for Unit 1 applicability. Specifically, Unit 1 operators were not trained on or aware of procedure revisions for loss of reactor coolant pump seal cooling and emergency diesel generator 1-1 cooling was not properly evaluated until questioned by the inspectors.
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07/24/1999	1999004	Pri: OPS Sec:	NRC	NEG	Pri: 3A Sec: 1C Ter:	The operations manual procedure change backlog was high but decreasing The operation manual procedure change backlog was high (1700) but decreasing. The changes not yet incorporated, although not critical for performance of the procedures, required operators to compensate through preevolution briefings or additional compensatory actions such as using partial procedures and caution tags. These actions placed additional burdens on the operating crews and were a type of operator workaround.
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07/24/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 3A Ter:	On July 16, Unit 2 operators took prompt action to isolate an electrical fault and deenergize the 2DF emergen On July 16, Unit 2 operators took prompt action to isolate an electrical fault and deenergize the 2DF emergency 4 kilovolt electrical bus. The nuclear shift supervisor and assistant nuclear shift supervisor quickly defined priorities and maintained orderly command and control. Coordination between system engineers, maintenance technicians, and operations personnel to safety restore the 2DF bus and associated loads was outstanding. Operators safety completed a technical specification required shutdown on July 18. Reference LER 50-412/99-06; LER 50-412/99-07..
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07/24/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: 1B Ter: 3A	Two operating crews responded well during simulator training scenarios. Two operating crews responded well during simulator training scenarios in their identification of equipment failures and emergency operating procedure usage. Simulator instructors were knowledgeable of the facility and effectively used lessons learned and industry information during the training. Fidelity issues with the simulator and the control room were effectively tracked and resolved.
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06/12/1999	1999003	Pri: OPS Sec:	NRC	NEG	Pri: 1B Sec: 3A Ter: 3C	Following a March 29 loss of 4kV bus event, the NSS made a poor configuration control decision. Following a March 29 loss of 4kV bus event, the nuclear shift supervisor made a poor configuration control decision when he secured the emergency diesel generator prior to isolating the degraded 2-5 battery charger which caused the event. Reference LER 50-412/99-05.
Dockets Discussed: 05000412 Beaver Valley 2						
06/12/1999	1999003	Pri: OPS Sec:	Licensee	NEG	Pri: 3A Sec: 2A Ter: 5A	Operators failed to properly evaluate a source range nuclear instrumentation surveillance test. Operators failed to properly evaluate a source range nuclear instrumentation surveillance test. Corrective actions were appropriate. Reference LER 50-412/99-01.
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06/12/1999	1999003	Pri: OPS Sec:	NRC	POS	Pri: 3A Sec: 4C Ter: 5B	The Onsite Safety Committee effectively recognized, reviewed, and evaluated plant changes affecting nuclear safety. The Onsite Safety Committee effectively recognized, reviewed, and evaluated plant changes affecting nuclear safety. The meetings were well organized as the meeting agenda and items under review were consistently distributed and reviewed in advance. This allowed the committee members to review a large volume of items and focus on the items with greatest safety significance.
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05/01/1999	1999002	Pri: OPS Sec:	NRC	MISC	Pri: 3C Sec: Ter:	Significant overtime worked for Unit 2 refueling outage Significant overtime was worked for the Unit 2 refueling outage, but hours were carefully tracked in accordance with procedures. While no events were attributed to fatigue or excessive workload, management of overtime, especially for operators (20 to 32 percent overtime), continued to be a challenge.
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03/20/1999	1999001	Pri: OPS Sec:	NRC	NEG	Pri: 5C Sec: 3A Ter: 5B	Corrective action program did not fully evaluate or resolve several recent deficient conditions. The corrective action program did not fully evaluate or resolve several recent deficient conditions, including compensatory actions associated with emergency bus degraded voltage instrumentation and technical specification (TS) limiting condition of operation action and surveillance requirements. Common factors included department manager acceptance of incomplete condition report investigations, insensitivity to TS requirements, and hesitancy to initiate condition reports. Following discussions with inspectors, senior management established a team to evaluate the corrective action deficiencies and determine whether underlying weaknesses exist.
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03/20/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter: 1C	Outage configuration control improved. Outage configuration control improved, based on implementation of the computer-based clearance system in May 1998, combined with additional clearance reviews by senior reactor operators and reactor operators. The clearances associated with the service water system and a residual heat removal valve repair were properly written and completed.
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03/20/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter: 5A	Refueling activities including the reactor cavity draindown were generally conducted well Refueling activities including the reactor cavity draindown were generally conducted well. Preevolution briefings, procedure adherence, and supervisor oversight were good. Technical specification (TS) surveillance requirements were met and were well controlled. Refueling personnel and Quality Services Unit personnel provided critical self-identification of problems and captured them into the corrective action program. Management oversight was evident in support of the activities.
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03/20/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 5A Ter:	Operators maintained comprehensive and accurate logs that clearly identified significant activities and appli Operators maintained comprehensive and accurate logs that clearly identified significant activities and applicable technical specification limiting conditions of operation. Plant problems described in the logs, were effectively transferred into the corrective action system for resolution.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
03/20/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: 5A Ter:	The Independent Safety Evaluation Group pre-outage safety review verified that the Unit 2 outage schedule p The Independent Safety Evaluation Group (ISEG) pre-outage safety review verified that the Unit 2 outage schedule provided sufficient safety margin. The ISEG provided a comprehensive ongoing review of work scope and schedule changes and real time assessment of plant risk throughout the refueling outage. Station personnel maintained an awareness of key safety parameters during the outage through effective communication of shutdown safety status sheet information on a shiftly basis.
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03/20/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 3A Sec: 5A Ter: 5C	Human performance was generally good. Human performance was generally good. Station personnel maintained a low tolerance threshold by identifying numerous minor human performance deficiencies at the beginning of the Unit 2 refueling outage. Management aggressively responded to these problems with a plant-wide work stoppage to review the problems, improve preevolution briefing standards, and reenforce self-checking techniques. Increased senior plant management observations of preevolution briefings added emphasis to self-checking techniques. These timely actions helped to prevent more significant human performance errors.
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03/20/1999	1999001-01	Pri: OPS Sec:	Licensee	NCV	Pri: 2B Sec: 3A Ter: 2A	Inadequate Source Range High Voltage Setpoint Leads to Failure to Comply with Technical Specifications An inadequate calibration procedure, due to unclear vendor technical information and a lack of understanding by the system engineer, resulted in plant operation with one of the two required source range nuclear instruments inoperable. The root cause and corrective actions were appropriate to preclude repetition. Reference LER 50-412/98-14. (Violation of TS 3.3.1; Enforcement Discretion per VII.B.1 of the Enforcement Policy.)
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02/06/1999	1998011	Pri: OPS Sec:	Self	NEG	Pri: 3A Sec: 1C Ter: 1A	Poor Procedures and Human Performance Weaknesses Result in a Loss of Main Condenser Vacuum and Sub Poor procedures and human performance weaknesses resulted in an uncontrolled reduction of main condenser vacuum and subsequent Unit 1 reactor trip during condenser waterbox cleaning. Poor procedures also caused an uncontrolled reduction of vacuum and turbine trip during unit restart.
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02/06/1999	1998011	Pri: OPS Sec:	NRC	NEG	Pri: 3A Sec: 5B Ter:	Condition Report Investigation Response Quality has Improved While condition report investigation response quality has improved since May 1998, the Corrective Action Review Board rejection rate continued to indicate a performance weakness.
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02/06/1999	1998011	Pri: OPS Sec:	NRC	NEG	Pri: 5C Sec: 3A Ter:	Corrective Action Implementation Following the Unit 1 Reactor Trip was Adequate Corrective action implementation following the Unit 1 reactor trip was adequate, yet some related procedural deficiencies, which could cause event recurrence, were not addressed until questioned by the inspectors.
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02/06/1999	1998011	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 5B Ter:	Unit 1 Operators Initiate a Manual Reactor Trip Unit 1 operators alertly initiated a manual reactor trip from 73% reactor power, when they could not recover main condenser vacuum. The event review team and the nuclear safety review board comprehensively reviewed the event and identified appropriate corrective actions prior to restart.
Dockets Discussed: 05000334 Beaver Valley 1						
02/06/1999	1998011	Pri: OPS Sec:	NRC	POS	Pri: 5B Sec: 3A Ter:	Off-Site Review Committee Meets Regulatory Requirements Off-Site Review Committee (ORC) meeting periodicity, content, and membership quorum met regulatory requirements. External ORC member participation has improved the quality of station chemistry and radiological audits.
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02/06/1999	1998011	Pri: OPS Sec:	NRC	POS	Pri: 5B Sec: 5A Ter: 4C	Condition Report Backlog has Decreased Approximately 50% The condition report investigation backlog has decreased approximately 50% since May 1998. The corrective action backlog, especially in the Engineering and Maintenance departments, remained high with over 1000 open items. Deficiencies continued to be identified and inputted into the corrective action system.
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02/06/1999	1998011	Pri: OPS Sec:	NRC	POS	Pri: 5C Sec: 3A Ter: 4C	Corrective Action Review Board Conducted Comprehensive Reviews of Condition Report Investigation Respo The Corrective Action Review Board (CARB) conducted comprehensive reviews of condition report investigation responses, with a rejection or table rate of 20%. CARB membership diversity contributed to noteworthy findings including a concern associated with the use of permanent caution tags and configuration control.
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02/06/1999	1998011-01	Pri: OPS Sec:	NRC	VIO IV	Pri: 1C Sec: 5B Ter: 5C	Inoperable Meteoroloigcal Tower Instrumentation Quality Services Unit personnel identified that procedures and practices may have been inadequate to assure technical specification (TS) surveillance requirements for meteorological monitoring instrumentation were satisfied. Investigation of the issue was incomplete and corrective actions were untimely. Absent NRC involvement, the licensee would not have recognized and reported several related violations of TS. These deficiencies represented a breakdown of the corrective action program across the organization and resulted in a violation. Reference LER 50-334(412)/98-29 (Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action.")
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01/08/2000	1999010	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: 3A Ter: 2A	POOR PLANNING AND RECOGNITION OF POTENTIAL EMERGENT WORK ACTIVITIES The out-of-service time for the supplementary leak collection and release system (primary auxiliary building ventilation) was extended due to poor planning and poor recognition of potential emergent work activities. Additional issues associated with high differential pressure across fire doors were appropriately captured in the condition report program.
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01/08/2000	1999010	Pri: MAINT Sec:	NRC	NEG	Pri: 5C Sec: 2A Ter:	NUCLEAR AND PROCUREMENT ENGINEERS RESPONSE TO SELF-ASSESSMENT FINDINGS Nuclear and procurement engineers were slow to respond to self assessment findings regarding control of parts. The lack of a timely response contributed to additional parts related problems and was a deficiency in condition report program implementation.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
01/08/2000	1999010	Pri: MAINT Sec:	NRC	NEG	Pri: 5C Sec: 5B Ter: 3A	CORRECTIVE ACTIONS TO THE PREVENTIVE MAINTENANCE PROGRAM Previous corrective actions to improve the preventive maintenance (PM) program were not performed in a timely fashion and exacerbated the PM program deficiencies. In addition, performance indicators were not used effectively to identify a degrading trend in the scheduled performance of PM tasks. Quality Services Unit personnel did not provide effective oversight of previously identified preventive maintenance program deficiencies.
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01/08/2000	1999010	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 2B Ter:	MAINTENANCE ACTIVITIES AND SURVEILLANCE TESTS Two maintenance activities and five surveillance tests were performed safely and in accordance with proper procedures.
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01/08/2000	1999010	Pri: MAINT Sec:	NRC	POS	Pri: 5B Sec: 2B Ter:	THE 1999 MAINTENANCE DEPARTMENT SELF-ASSESSMENTS AND QUALITY SERVICE UNIT MAINTENANCE AU The 1999 Maintenance department self-assessments and Quality Services Unit maintenance audit were critical and provided good insight for improvement. Corrective actions were scheduled and completed in a timely manner.
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01/08/2000	1999010	Pri: MAINT Sec:	NRC	POS	Pri: 5B Sec: 5C Ter:	MULTI-DISCIPLINED ASSESSMENT TEAM The Multi-Discipline Analysis Team assessment of preventive maintenance program deficiencies was detailed and critical. Interim corrective actions were comprehensive.
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01/08/2000	1999010-02	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: 3A Ter: 2A	DEFERRED PREVENTIVE MAINTENANCE Preventive maintenance (PM) tasks were deferred beyond their periodicities, without the proper evaluations required by the PM program procedure. Failure to perform PMs on safety related equipment is a violation of Technical Specification (TS) 6.8.1. Enforcement discretion per Section VII.B.1.a. (Condition Report 993581).
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01/08/2000	1999010-03	Pri: MAINT Sec: ENG	Self	EEI	Pri: 5A Sec: 5C Ter: 2A	INADEQUATE CORRECTIVE ACTIONS FOR DEGRADED RIVER WATER/SERVICE WATER VACUUM CHECK VALV Inadequate corrective actions for a longstanding degraded material condition resulted in a water hammer event on November 9, 1999, that deformed an expansion joint and created an adverse condition which challenged the operability of service water pump 2SWS-P21C. Plant personnel missed opportunities to identify and take appropriate action in response to this condition. Prior to identification of the deformed expansion joint on November 21, 1999, operators removed a second service water pump from service for planned maintenance, thereby placing Unit 2 outside of its design basis. Performance weaknesses included poor understanding of the potential safety significance of the degraded material condition, preventive maintenance deficiencies, untimely assessment and design change implementation, and poor communications during the event investigation.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
11/27/1999	1999009	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: 2B Ter:	The corrective maintenance backlog reduction plan was effective The corrective maintenance backlog reduction plan was effective in reducing the backlog to the end of year goal of 800. Increased management focus and process improvements were responsible for the reductions. A review of the corrective maintenance backlog indicated that it generally represented the plant material condition. The Work Control Screening Committee properly classified and prioritized equipment deficiencies. Higher priority deficiencies were promptly corrected.
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10/16/1999	1999008	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Four maintenance work activities and seven surveillance tests were completed. Four maintenance work activities and seven surveillance tests were completed safely with appropriate management oversight. However, a plant operator did not recognize increased steam and water leakage as degraded conditions during the Unit 1 steam driven auxiliary feedwater pump surveillance test.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
10/16/1999	1999008	Pri: MAINT Sec:	Licensee	POS	Pri: 3A Sec: 1C Ter:	Station personnel demonstrated initiative by using industry experience and lessons learned from previous NRC Station personnel demonstrated initiative by using industry experience and lessons learned from a previous NRC violation to identify four missed TS surveillance tests. The events were of minimal safety significance.
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10/16/1999	1999008	Pri: MAINT Sec:	NRC	POS	Pri: 5B Sec: 3A Ter: 4B	Electricians, engineers, and vendor representatives communicated effectively and safely performed troubles Electricians, engineers, and vendor representatives communicated effectively and safely performed comprehensive troubleshooting to investigate the failed Unit 1 main unit generator voltage regulator. Although the cause was not conclusively identified, the investigation and corrective actions were reasonable to preclude recurrence of the event.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
10/16/1999	1999008	Pri: MAINT Sec:	NRC	WK	Pri: 1A Sec: 2B Ter: 5C	Station personnel identified seven additional missed Technical Specification Surveillances. Station personnel identified seven additional missed technical specification (TS) surveillances since February 1999. Three of the seven reflected current performance deficiencies and were caused by human error. The remaining four were old issues, due primarily to longstanding procedure deficiencies. While the safety significance of the individual missed tests was low, the continued examples of missed surveillance tests indicate that previous corrective actions have not been fully effective at ensuring TS surveillance tests are performed as required. Reference LERs 50-334/99-05, 99-08, 99-09, and 50-412/99-08.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
10/21/1999	01013-99212	Pri: MAINT Sec:	NRC	VIO III	Pri: 4B Sec: 3A Ter: 2B	Failure to Implement Corrective Actions for Biofouling In 1995, the licensee developed a plan for the prevention of biofouling in the service water system. Although plans for the type of biocide treatments were established, frequencies for those treatments were not included in the plan. Subsequently, the licensee failed to perform these treatments consistently and frequently enough to be effective. An increase in the Zebra mussel population at the service water intake structure in 1998 was a missed opportunity to identify this problem. The failure to consistently perform routine biocide treatments in 1998 and 1999, coupled with the performance of ineffective bulk biocide treatments during this period, allowed zebra mussels to accumulate in the service water system. As a result, following a bulk biocide treatment in July 1999, the heat exchanger for the Emergency Diesel Generator 2-2 became fouled with zebra mussels, which significantly degraded the cooling water flow through the heat exchanger. Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." A violation was issued by EA letter 99-212, Item 02013. Reference NRC IR Nos. 50-334(412)/99-07.
Dockets Discussed: 05000412 Beaver Valley 2						

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10/21/1999	01023-99212	Pri: MAINT Sec:	NRC	VIO III	Pri: 4B Sec: 2B Ter: 3A	Inadequate Procedure for Chemical Treatment The licensee failed to provide adequate acceptance criteria in its procedure for bulk chemical treatments of the service water system. Specifically, the emergency diesel generators were not monitored to assess the impact of biofouling dislodged during the treatment. The lack of acceptance criteria coupled with the simultaneous treatment of both service water trains, created the potential for a common mode failure and a significant reduction in safety margins. Consequently, use of the procedure on July 7, 1999, to clean the service water piping of zebra mussels resulted in biofouling of the 2-2 EDG service water heat exchanger and restricted the water flow to 1070 gpm, which was below the design basis minimum requirement of 1170 gpm. This flow degradation remained undetected until an EDG surveillance test was conducted on July 14, 1999. Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." Reference IR Nos. 50-334(412)/99-07.
Dockets Discussed: 05000412 Beaver Valley 2						
08/27/1999	1999006	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: 3A Ter: 5A	Work groups kept Measuring and Test Equipment instruments for extended periods of time. Work groups kept Measuring and Test Equipment (M&TE) instruments for extended periods of time (i.e., 30 to 90 days). The potential exists for an incomplete review of the affects on equipment from M&TE which is subsequently found to be out-of-calibration. This appears to be a known weakness within the M&TE program, but had not been documented in a corrective action program.
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08/27/1999	1999006	Pri: MAINT Sec:	NRC	NEG	Pri: 5C Sec: 2B Ter:	Material deficiencies associated with safety-related or Technical Specification equipment Material deficiencies associated with safety-related or Technical Specification equipment were inconsistently documented and tracked, sometimes under the Maintenance Work Request program, by using a material deficiency tag, and sometimes under the Condition Reporting program. Several examples were identified where corrective actions were slow for safety-related deficiencies identified in 1997 and 1998.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
08/27/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 4B Sec: 5C Ter:	The problem identification and corrective action aspects of the Maintenance Rule Program. The problem identification and corrective action aspects of the Maintenance Rule program were well managed, appropriately implemented by system engineering, and appeared effective in identifying system problems and improving system performance.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
08/27/1999	1999006-01	Pri: MAINT Sec:	NRC	NCV	Pri: 4B Sec: 4A Ter: 3A	Gaseous Waste Oxygen Analyzer Design Control Deficiency Operations failed to monitor the correct flow indicator for the gaseous waste oxygen analyzer sample flow for a three year period, due to a failure to adequately translate a 1996 design change into operator logs and plant equipment labeling. Operation and Maintenance personnel missed several opportunities in 1999 to identify the discrepancy. (Violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," Enforcement Discretion per Appendix C of the NRC Enforcement Policy)
Dockets Discussed: 05000412 Beaver Valley 2						

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09/04/1999	1999005	Pri: MAINT Sec:	NRC	NEG	Pri: 2A Sec: 2B Ter:	Maintenance work backlog is high. Degraded equipment forced shutdowns. Additional contractor support and improved work order tracking were used to reduce the non-outage corrective maintenance backlog slightly to 975 items over the last six months. While no immediate operability concerns were identified, the current backlog remains above the station's year-end goal of 800 items and maintenance schedule adherence remained low. Degraded equipment has contributed to several forced shutdowns and continued material condition improvements are warranted.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
09/04/1999	1999005	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3C Ter:	Maintenance procedure revision backlog was high but decreasing. The maintenance procedure revision backlog was high (980) but decreasing, with appropriate emphasis on the higher priority procedures. The program for controlling the procedures needing revisions was good.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
07/29/1999	1999007-03	Pri: MAINT Sec:	NRC	EEl	Pri: 5B Sec: 4B Ter: 3A	Macro biological fouling (biofouling) in the service water piping Macro biological fouling (biofouling) in the service water piping that supplies the diesel generator was not detected during a biocide treatment on July 7. Seven days later, a rapid and substantial degradation of service water flow occurred during an unrelated diesel generator surveillance test. The management team was slow to understand the effects of the July 7 biocide treatment for common mode failure and failed to protect EDG 2-1 from heat exchanger fouling. This series of events resulted in Emergency Diesel Generator 2-2 being inoperable for longer than the 72-hour allowed outage time of the Technical Specifications. Additionally, the initial plan for EDG 2-2 operability restoration was incomplete, until challenged by the inspectors. This apparent violation of TS 3.8.1.1 is being considered for escalated enforcement action. Closed by NRC letter to BVPS dated October 21, 1999. Apparent violation withdrawn.
Dockets Discussed: 05000412 Beaver Valley 2						
07/29/1999	1999007-05	Pri: MAINT Sec:	NRC	NCV	Pri: 3A Sec: Ter:	On July 7, a chemistry technician failed to follow the procedure for sampling of the service water system during a bulk chemical treatment activity. On July 7, a chemistry technician failed to follow the procedure for sampling of the service water system during a bulk chemical treatment activity. As a result, the intended biocide concentration was not applied to the "A" train of service water. This failure to follow procedures is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. (Violation of TS 6.8.1)
Dockets Discussed: 05000412 Beaver Valley 2						
07/24/1999	1999004	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: 1C Ter: 4B	The Units 1 and 2 auxiliary feedwater systems were in overall good material condition. The Unit 1 and 2 auxiliary feedwater systems were in overall good material condition as demonstrated by high maintenance rule system availability and low backlog of work orders. Open engineering items were properly prioritized and tracked.
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07/24/1999	1999004	Pri: MAINT Sec:	NRC	WK	Pri: 3A Sec: 1C Ter: 2A	Work delays for several Unit 1 activities either increased plant risk or required operations personnel tochang Work delays for several Unit 1 activities either increased plant risk or required operations personnel to change their planned schedule and make additional plant manipulations. Several factors contributed to poor work schedule implementation including operations and maintenance manpower constraints, poor communication between operations and maintenance personnel, untimely and incomplete work package planning, and poor quality pre-job walkdowns. The poor work schedule implementation represented a programmatic weakness.
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07/24/1999	1999004-01	Pri: MAINT Sec:	NRC	NCV	Pri: 1C Sec: 4A Ter: 3A	In March 1999, poor planning and recognition of the importance of chain hoists to support the Unit 2 equipme In March 1999, poor planning and failure by maintenance personnel to recognize of the importance of chain hoists to support the Unit 2 containment equipment hatch was the root cause of the hatch not being fully closed during fuel movement. Reference LER 50-412/99-03. (Violation of TS 3.9.4. Enforcement discretion per Appendix C of the NRC Enforcement Policy)
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
06/12/1999	1999003	Pri: MAINT Sec:	NRC	NEG	Pri: 2A Sec: 2B Ter: 3A	In one instance, corrective maintenance for a degraded river water pump was not performed in a timely mar In one instance, corrective maintenance for a degraded river water pump was not performed in a timely manner. The delay reflected communications and scheduling deficiencies for time sensitive recommended maintenance.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
06/12/1999	1999003	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: 3A Ter:	A minor weakness in the ownership and control of materials being staged to support the 12-week schedule A minor weakness in the ownership and control of materials being staged to suport the 12-week schedule was identified and captured in the corrective action program.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
06/12/1999	1999003	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3A Ter:	On-line maintenance was performed safely and in accordance with proper procedures. On-line maintenance was managed consistent with equipment availability assumptions contained in the Beaver Valley Unit 1 & 2 Probabilistic Risk Assessments. The on-line maintenance procedure was comprehensive and well understood. Incorporation of maintenance rule insights was a strength. Work week managers actively tracked and communicated job status to the Nuclear Shift Supervisor (NSS), which support sound decision making with respect to configuration control. Occasional performance deficiencies, such as NSS authorization of work without recognizing system operability relationships were properly addressed through the condition report system.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
06/12/1999	1999003	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 4B Ter: 2A	Surveillance testing was performed safely. Surveillance testing was performed safely, with appropriate supervisory attention, and in accordance with proper procedures. System engineers and maintenance personnel coordinated effectively to investigate an unexpected 2-4 vital bus inverter transfer to its alternate power supply.
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06/12/1999	1999003	Pri: MAINT Sec:	NRC	POS	Pri: 5C Sec: 2B Ter: 3A	In response to an NRC violation, the licensee took strong actions to reiterate station policy for safe operation In response to an NRC violation, the licensee took strong actions to reiterate station policy for safe operation and maintenance of plant equipment. Training was effective and lessons learned from the violation were stressed during pre-evolution briefings for subsequent auxiliary feedwater pump tests. Reference VIO 50-334/98-04-01.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
05/01/1999	1999002	Pri: MAINT Sec:	NRC	NEG	Pri: 1C Sec: 2B Ter:	Surveillance procedure deficiencies involving incomplete precautions, initial conditions, and acceptance crit Surveillance procedure deficiencies involving incomplete precautions, initial conditions, and acceptance criteria continued to challenge the operating staff.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
05/01/1999	1999002	Pri: MAINT Sec:	Self	NEG	Pri: 2A Sec: 2B Ter: 3A	Unit 1 main generator hydrogen seal oil pressure degraded Unit 1 main unit generator hydrogen seal oil pressure degraded during unit restart from the surveillance testing outage. Corrosion products fouled the seal oil system filters and forced a plant shutdown from 15% power. Reference PN1-99-021.
Dockets Discussed: 05000334 Beaver Valley 1						
05/01/1999	1999002	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 2B Ter:	Post-maintenance testing requirements were properly specified and performed Post-maintenance test (PMT) requirements were properly specified and performed following equipment maintenance during the Unit 2 refueling outage and the Unit 1 surveillance testing outage. Senior reactor operators assigned to the one-stop-shop effectively managed PMT schedule implementation and ensured equipment was promptly restored to service following planned maintenance.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
05/01/1999	1999002	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 3B Ter: 5A	Twelve surveillance tests were performed well with strong preevolution briefings. Twelve surveillance tests were performed well with strong preevolution briefings. In most cases, operators successfully identified and compensated for procedure deficiencies prior to performing the surveillance test.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
05/01/1999	1999002	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 3C Ter: 2B	Work activities were safely coordinated through the one-stop-shop Work activities were safely coordinated through the one-stop-shop during the Unit 2 refueling and Unit 1 surveillance testing outages. The improved work activity coordination effectively reduced burden on the control room staff. The reduced burden enabled the nuclear shift supervisors to focus more directly on maintaining safe shutdown plant conditions and contributed to improved human performance.
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03/20/1999	1999001	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: 3A Ter: 2B	The preventive maintenance program effectively maintained and performance testing monitored the safety r The preventive maintenance program effectively maintained and performance testing monitored the safety related heat exchangers.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
03/20/1999	1999001	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3A Ter:	Nine observed planned maintenance activities were performed safely and in accordance with maintenance w The nine observed planned maintenance activities, including station battery replacement, auxiliary feedwater pump inspection, and residual heat system valve repair, were performed safely and in accordance with maintenance work instructions. The work packages, including post-maintenance testing requirements, were good. Maintenance supervisors demonstrated good job ownership and leadership in the field.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
03/20/1999	1999001	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 5A Ter: 3C	Seven observed surveillance tests were performed safely and in accordance with proper procedures. The seven observed surveillance tests were performed safely and in accordance with proper procedures. Management placed more emphasis on preevolution briefings for infrequently performed evolutions following several minor human performance deficiencies observed early in the refueling outage. The assignment of test directors, the quality of preevolution briefings, and test implementation for safety injection full flow tests were excellent.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
02/06/1999	1998011	Pri: MAINT Sec:	Self	NEG	Pri: 2A Sec: 3A Ter:	Poor Material Condition Prevented Station Personnel from Routinely Chlorinating the Unit 1 Circulating Wate Poor material condition of the chlorination system prevented station personnel from routinely chlorinating the Unit 1 circulating water system to preclude marine fouling during the past several months. Main condenser performance significantly degraded, which necessitated condenser waterbox isolation and cleaning. This evolution led to an uncontrolled reduction of condenser vacuum requiring operators to manually trip the reactor. Reference LER 50-334/99-01.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
02/06/1999	1998011	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: 2B Ter: 5A	In Some Cases, Such as Unit 1 LHSI, Safety Related System Unavailability was Not Effectively Managed In some cases, such as Unit 1 low head safety injection, safety related system unavailability was not effectively managed, due to work scheduling and coordination deficiencies.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
02/06/1999	1998011	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 1A Ter: 3B	Four Surveillance Tests were Performed Safely and in Accordance with Proper Procedures. Four surveillance tests were performed safely and in accordance with proper procedures. Field operators effectively supported surveillance tests.
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02/06/1999	1998011	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 3B Ter: 4B	Three Routine Maintenance Activities were Performed Safely and in Accordance with Proper Procedures. Three routine maintenance activities were performed safely and in accordance with proper procedures. An emergent Unit 2 service water pump work activity was properly planned and implemented. The control room door was safely repaired due to good coordination between engineering personnel, operators, and maintenance planners.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
02/06/1999	1998011	Pri: MAINT Sec:	NRC	STR	Pri: 4B Sec: 2A Ter: 2B	Maintenance Rule Program Continued to Properly Monitor the Effectiveness of Maintenance The maintenance rule program continued to properly monitor the effectiveness of maintenance. The periodic program assessment demonstrated strong system engineering involvement and monitoring of the program and individual systems. The effectiveness of corrective actions was generally good for systems evaluated under the (a)(1) category.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
02/06/1999	1998011-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 3A Sec: 4B Ter: 2B	Inappropriate Surveillance Testing Results in Unit 2 Control Room Emergency Ventilation System Upplanned I Poor self checking, failure to perform a procedure in the sequence it was written, and insufficient post maintenance testing requirements resulted in the "B" Control Room Emergency Ventilation System train being unrecognized as inoperable for two days. (Violation of TS 6.8.1.c; Enforcement Discretion per VII.B.1 of the Enforcement Policy.)
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
11/27/1999	1999009	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: 5B Ter: 5C	The initial corrective actions to improve operating procedures associated with loss of reactor coolant pump s The initial corrective actions to improve operating procedures associated with loss of reactor coolant pump seal cooling were incomplete. The engineering justification for procedure changes did not contain sufficient information to support the change. The abnormal operating procedure and alarm response procedures to address reactor coolant pump cooling problems were inconsistent in format and did not communicate key information well. Subsequent corrective actions, in response to the inspectors' concerns, adequately addressed both deficiencies.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
10/16/1999	1999008	Pri: ENG Sec:	NRC	POS	Pri: 3A Sec: 4C Ter:	Licensee amendment requests, including requests to revise nonconservative technical specifications, were b Licensee amendment requests, including requests to revise nonconservative technical specifications, were being completed in a timely manner.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
10/16/1999	1999008	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 3A Ter:	System engineers effectively identified the cause of a failed 4kV bus supply breaker. System engineers effectively identified the cause of a failed 4kV bus supply breaker. Engineers and electrical technicians coordinated closely to determine the extent of condition and perform appropriate repairs to all affected 4kV breakers.
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10/16/1999	1999008	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 4C Ter: 3A	Temporary modifications were appropriately controlled. Temporary modifications were appropriately controlled and scheduled for removal in accordance with the priority of the specific item.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
08/27/1999	1999006	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 4C Ter:	The Quality Services Unit has been conducting effective audits of the Nuclear Engineering Department. The Quality Services Unit has been conducting effective audits of the Nuclear Engineering Department. These audits were performed in sufficient detail and with a constructive and critical attitude. Corrective actions were found effective and the details were handled in a professional manner.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
09/04/1999	1999005	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: 5B Ter: 5C	The initial evaluation of elevated reactor coolant average temperatures above the normal programmed band The initial evaluation of elevated reactor coolant average temperatures above the normal programmed band during reactor startups, was not rigorous or documented. Subsequent detailed evaluations were technically sound and confirmed that the units had not been operated outside of the design bases of the plant.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
09/04/1999	1999005-02	Pri: ENG Sec:	NRC	NCV	Pri: 5C Sec: 3A Ter: 4A	Failure to Promptly Evaluate and Correct Identified Engineering Deficiencies The engineering backlog remained high (1800 open items). The overall prioritization of the items was appropriate. However, the overall size of the backlog and number of resource intensive items (Unit 2 small bore piping evaluations, Unit 1 nitrogen backup modifications, etc.) resulted in other items being resolved slowly as compared to their safety significance. These included resolution of a possible unreviewed safety question and incorrect steam generator tube rupture analysis design assumptions. Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action;" Enforcement Discretion per Appendix C of the NRC Enforcement Policy. See Condition Report 992491.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
07/29/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 2A Ter:	Equipment aligned to the 4kV emergency bus that was affected by the EDG 2-2 failure responded as expected Equipment aligned to the 4 kV emergency bus that was affected by the EDG 2-2 failure responded as expected during the low voltage condition which existed for approximately 75 seconds. The licensee's engineering evaluations for loads that were running, or received start signals, were technically sound. In addition, electrical tests were used to confirm the condition of the affected equipment.
Dockets Discussed: 05000412 Beaver Valley 2						
07/29/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 5C Ter: 2A	The licensee identified the most probable cause of the EDG 2-2 failure The licensee identified the most probable cause of the EDG 2-2 failure on July 16 as an intermittent control relay contact in the voltage regulator circuit. A questioning attitude throughout the engineering evaluation and root cause analysis was observed, and the licensee made effective use of the vendor support. The voltage regulator repairs and retest were appropriate. Long term corrective actions recommended by the Event Response Team are reasonable actions to prevent recurrence of the relay failure.
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07/29/1999	1999007-07	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: 4B Ter:	The safety-related 125 volt batteries and DC system responded normally during the loss of power to their chargers. The safety-related 125 volt batteries and DC system responded normally during the loss of power to their chargers. TS requirements for the DC distribution system were appropriately implemented. The licensee's engineers provided a reasonable assessment of the batteries' performance during this event and concluded that the battery discharge rates were within their design.
Dockets Discussed: 05000412 Beaver Valley 2						
07/29/1999	1999007-08	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 5B Ter:	The licensee appropriately evaluated the operational condition of the reactor coolant pump The licensee appropriately evaluated the operational condition of the reactor coolant pump (RCP) seals after the loss of all seal cooling (concurrent loss of both seal injection and thermal barrier flow). Based on plant data taken before, during, and after the event, the licensee determined no significant heat up of the seals occurred.
Dockets Discussed: 05000412 Beaver Valley 2						
07/24/1999	1999004	Pri: ENG Sec:	Licensee	MISC	Pri: 5C Sec: 5A Ter: 5B	Licensee identification of three recent violations of technical specification setpoint or calibration requirement Licensee identification of three recent violations of technical specification (TS) setpoint or calibration requirements demonstrate improved questioning attitudes by station personnel. However, they also demonstrate that previous activities such as the 1997-1998 TS surveillance review project and the ongoing Updated Final Safety Analysis Report verification project were not of sufficient depth to identify these TS non-compliances. Programmatic corrective actions, including continued Engineering Safety Principles training were adequate to improve station personnel's awareness of TS requirements. Reference LERs 50-334/99-03 and 50-412/99-04.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
07/24/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 1C Ter: 3A	The Industry Operating Experience program instruction was comprehensive and effectively managed. The Industry Operating Experience (IOE) program instruction was comprehensive and effectively managed and backlogs were reduced by 30%. Engineers and operations personnel understood the IOE program and actively used the IOE database. Evaluations were typically thorough, technically sound, and clearly documented in IOE Positions Statements. Application of industry information regarding electrical circuit breaker maintenance and testing was a strength. IOE engineers actively communicated station issues which held potential generic industry interest.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
07/24/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 2A Ter: 5C	The long-standing Problem Review Team effectively selected, prioritized, and resolved longstanding equipment The Long-Standing Problem Review Team effectively selected, prioritized, and resolved long-standing equipment problems affecting the efficiency, reliability, and safety of Beaver Valley Power Station plant operations. The completed resolutions to the long-standing equipment problems were technically sound. The problems in process of resolution were being addressed in a careful and timely manner commensurate with their difficulty and safety significance.
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07/24/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 3A Ter: 5C	System and design engineers provided good support on emergent Unit 2 shutdown issues. System and design engineers provided good support on emergent Unit 2 shutdown issues such as check valve leakage in the safety injection and auxiliary feedwater systems.
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08/10/1999	9906090003	Pri: ENG Sec:	NRC	LIC	Pri: 4B Sec: 3A Ter:	In general, licensing submittals have been technically adequate. In general, licensing submittals have been technically adequate and timely. However, the attention to detail in submittals has been inconsistent. For example: 1) The licensee's July 9, 1998 submittal, which requested revision of the maximum allowable reactor power level based on the number of operable main steam safety valves, included technical specification changes which were not addressed in the licensee's application for technical specification amendment. 2) The licensee's December 24, 1998 submittal which requested relocation or deletion of technical specification requirements was technically insufficient with regard to the Unit 1 rod position deviation. (Contact: D. Collins/NRR)
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
08/02/1999	9904220122	Pri: ENG Sec:	NRC	LIC	Pri: 4B Sec: 3A Ter:	Submittal of a one-time Technical Specification extension of the Unit 1 steam generator inspection interval w Submittal of a one-time technical specification extension of the Unit 1 steam generator inspection interval was not timely. The November 11, 1998 submittal requested issuance of the amendment by December 30, 1998, which allowed the staff insufficient time to complete their reviews and meet the requested completion date. (Ref: DPR-66 License Amendment 221, issued April 16, 1999) (Contact: D. Collins/NRR)
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
06/12/1999	1999003	Pri: ENG Sec:	NRC	MISC	Pri: 4B Sec: 4C Ter:	The nuclear engineering self-assessments reviewed satisfied administrative requirements. The nuclear engineering self-assessments reviewed satisfied administrative requirements and confirmed expected results. However, the assessments did not provide substantial recommendations or corrective actions.
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06/12/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 2B Sec: 3A Ter:	Controls for the receipt, storage, and handling of safety-related equipment and material were effectively mai Controls for the receipt, storage, and handling of safety-related equipment and material were being effectively maintained.
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06/12/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 3B Sec: 4B Ter: 3A	The licensee established, implemented, and maintained an effective ventilation system surveillance program The licensee established, implemented, and maintained an effective ventilation system surveillance program with respect to charcoal adsorption surveillance tests, high efficiency particulate and charcoal filters mechanical efficiency tests, and air flow rate tests.
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/12/1999	1999003	Pri: ENG Sec:	Licensee	POS	Pri: 4B Sec: 2A Ter: 5B	The licensee properly evaluated and reported January 1999 Unit 1 degraded condenser vacuum reactor trip e The licensee properly evaluated and reported the January 1999 Unit 1 degraded condenser vacuum reactor trip event. Corrective actions were appropriate and engineers performed a detailed assessment which correctly elevated the circulating water system into Maintenance Rule category (a)(1) performance monitoring.
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06/12/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 2B Ter: 5B	System engineers recently performed good trending of Unit 1 river water pump performance. System engineers recently performed good trending of Unit 1 river water pump performance. Performance data was carefully reviewed and used to determine pump maintenance frequency.
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06/12/1999	1999003	Pri: ENG Sec:	Licensee	POS	Pri: 4B Sec: 5B Ter: 5C	Engineers identified and corrected several nonconservative assumptions used in dose assessment calculation Engineers identified and corrected several nonconservative assumptions used in dose assessment calculations for design basis accidents (DBA). For two DBA types, the errors could have permitted control room operator radiological dose to exceed regulatory requirements. Extent of condition causal analysis, basis for continued operation evaluations, and 10 CFR 21 reporting were comprehensive. Reference LER 50-334(412)/99-02.
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05/01/1999	1999002	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 3B Ter: 3A	Good root-cause assessment by system engineers and maintenance personnel provided timely corrective act Good root-cause assessment by system engineers and maintenance personnel provided timely corrective actions for several safety-related Unit 2 refueling outage equipment problems. A system engineer was aggressive in his resolve to identify and correct a Unit 1 repetitive breaker problem.
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05/01/1999	1999002	Pri: ENG Sec: OPS	Self	NEG	Pri: 4B Sec: 3A Ter: 5B	4 kV supply breaker tripped resulting in a loss of offsite power to the Unit 2 'A' train emergency bus. On March 29, while shutdown, a 4 kV supply breaker tripped resulting in a loss of offsite power to the Unit 2 "A" train emergency bus. The emergency diesel generator started and reenergized the emergency bus as designed. System engineer confusion and communication deficiencies delayed isolation of a degraded battery charger, which caused the event. Additionally, the Nuclear Shift Supervisor made a poor configuration control decision when he secured the emergency diesel generator prior to isolating the degraded 2-5 battery charger from the battery bus. This increased the likelihood of a repeat event. Reference LER 50-412/99-05.
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03/20/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 3A Ter: 3B	Two Unit 2 design changes were properly implemented to correct risk significant deficiencies. Two Unit 2 design changes were properly implemented to correct risk significant deficiencies which had necessitated longstanding operator workarounds. The service water pump seal supply modification was well written including a detailed safety evaluation and comprehensive installation test plan. Engineers demonstrated thorough knowledge of the design change and closely monitored both installation and testing. Foreign material exclusion controls, configuration controls, and communications were appropriate during design change installation and testing.
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03/20/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 3A Ter: 3C	System engineers activity supported planned work activities during the Unit 2 refueling outage. System engineers actively supported planned work activities during the Unit 2 refueling outage.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
03/20/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 3A Ter: 4A	System engineers conducted comprehensive monitoring and assessment of safety related heat exchangers. System engineers conducted comprehensive monitoring and assessment of safety related heat exchangers.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
03/20/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 3A Ter:	Planning and implementation of second 10-year interval Planning and implementation of the second 10 year interval, first period, inspection, including comprehensive steam generator inspections, was consistent with American Society of Mechanical Engineers (ASME) Boiler and Pressure Vessel Code (B&PVC) Section XI requirements.
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03/20/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 3A Ter:	Unit 2 refueling outage number 7 nondestructive examinations. Unit 2 refueling outage number 7 nondestructive examinations were implemented in accordance with ASME B&PVC Section XI and Section III rules for magnetic particle, ultrasonic, and radiographic examination and were performed by qualified and certified inspectors using acceptable procedures. Stuck reactor vessel head closure studs were properly evaluated.
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11/27/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Records of calibration for instruments used in support of radiation protection program were determined to be Records of calibration for instruments used in support of the radiation protection program were determined to be complete and accurate. Documentation of as-found calibration results, together with the establishment of an investigation level for these results, was determined to be an effective licensee initiative for maintaining accuracy in its radiological surveillance program. The program and records in support of personnel exposure measurements, including whole body counting, was appropriately implemented and maintained.
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11/27/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: Ter:	Appropriate planning and implementation of ALARA controls during 2R99 were evident Appropriate planning and implementation of ALARA controls during the unplanned Unit 2 outage (2R99) were evident. Changes in plant radiological conditions as a result of the unit restart were appropriately monitored and controlled.
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11/27/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 4B Sec: 4C Ter: 5C	Engineers performed a detailed review of their post-fire safe shutdown program Engineers performed a detailed review of their post-fire safe shutdown program to resolve issues identified in Problem Report 2-96-789. The scope and adequacy of the reviewed areas were acceptable. The self-assessment identified several procedural deficiencies, as well as the need to perform a multiple high level impedance fault analysis. These items were placed into the licensee's corrective action process for resolution. Additionally, the licensee properly issued licensee event reports for issues that were reportable. Reference LERs 50-412/99-02, 50-334/99-04, and 50-334/99-06.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
11/27/1999	1999009-02	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 5C Sec: 4B Ter:	Inadequate fire protection safe shutdown procedure Several fire protection safe shutdown procedures were inadequate. Corrective actions for some fire protection program audit identified deficiencies (particularly safe shutdown analysis actions not being properly implemented in the post-fire shutdown procedures) had not been completed for a significant time period. Violation of license conditions for fire protection program. Enforcement discretion per Section VII.B.1.a of the NRC Enforcement Policy. Reference/NRC IR 50-334(412) 99-08 and LERs 50-412/99-02, 50-334/99-04, and 50-334/99-06.
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08/27/1999	1999006	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 3A Ter:	Few security issues have been identified in the past 3 years. Few security issues have been identified the past three years. The security department self-identifies program refinements and improvements through an active and robust surveillance program.
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09/04/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 2A Sec: 4C Ter:	The onsite emergency facilities were maintained ready for response to an emergency The onsite emergency facilities were maintained ready for response to an emergency. Improvements were implemented to more efficiently make offsite notifications. Communication testing procedures and inventories were completed as required. No deficiencies were noted in the 10 CFR 50.54(q) evaluations for the latest two emergency plan revisions. The licensee's annual EP program audits were comprehensive, organized, and detailed.
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09/04/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 3B Sec: 3A Ter:	The program for training the senior Emergency Response Organization members was effective. The onsite emergency facilities were maintained ready for response to an emergency. Improvements were implemented to more efficiently make offsite notifications. Communication testing procedures and inventories were completed as required. No deficiencies were noted in the 10 CFR 50.54(q) evaluations for the latest two emergency plan revisions. The licensee's annual EP program audits were comprehensive, organized, and detailed.
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06/12/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: 3B Ter: 1C	A generally effective program for maintaining occupational exposures as low as is reasonably achievable has been established. A generally effective program for maintaining occupational exposures as low as is reasonably achievable (ALARA) has been established. Management involvement in the ALARA program, incorporation of ALARA principles into plant modifications, and establishment of exposure goals were appropriate. An effective training program for ALARA has been implemented for both radiological workers and radiation protection technicians.
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06/12/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: 3B Ter: 1C	Radioactive liquid and gaseous effluent control programs were effective Radioactive liquid and gaseous effluent control programs were effective. The Offsite Dose Calculation Manual contained sufficient specification and instruction to acceptably implement and maintain the radioactive liquid and gaseous effluent control programs. The Quality Assurance and Quality Control programs to validate radioactive liquid and gaseous effluent control program analytical results were effective.
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05/01/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 2A Sec: 3A Ter:	Housekeeping was good for Unit 1 containment at conclusion of Unit 1 surveillance outage activities Housekeeping, including storage of equipment, boric acid leaks, and structural support condition, was good for the Unit 1 containment at the conclusion of Unit 1 surveillance outage activities.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
05/01/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: 3A Ter:	Radiation protect program was effective during the Unit 2 refueling outage The radiation protection program was effective during the Unit 2 refueling outage. Appropriate controls for personnel radiation protection were established in the radiologically controlled areas. Enhanced informational postings, especially in the containment, aided in maintaining occupational exposures as low as is reasonably achievable (ALARA).
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05/01/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 5B Ter:	Scope and depth of Quality Services Unit surveillances were adequate to identify and document program de The scope and depth of Quality Services Unit surveillances conducted for the Unit 2 refueling outage, and as part of the annual health physics program audit, were adequate to identify and document program deficiencies. All identified deficiencies were entered into the condition report program and tracked through resolution.
Dockets Discussed: 05000334 Beaver Valley 1 05000412 Beaver Valley 2						
03/20/1999	1999001	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: 5B Ter:	Fitness-for-Duty and Security Program audits were comprehensive in scope and depth. The Fitness-for-Duty and Security Program audits were comprehensive in scope and depth, audit findings were reported to the appropriate level of management, and the audit program was being properly administered. In addition, a review of the documentation applicable to the self-assessment program indicated that the program was being effectively implemented to identify and resolve potential weaknesses.
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03/20/1999	1999001	Pri: PLTSUP Sec:	NRC	POS	Pri: 3C Sec: 3A Ter:	Security force members were properly trained, equipment properly maintained, and security and safeguards Security force members were properly trained, security equipment was properly maintained, and security and safeguards activities were effectively conducted in a manner that protected public health and safety in the areas of access authorization, alarm stations, communications, and protected area access control of personnel and packages. Management support was adequate to ensure effective implementation of the security program, and was evidenced by adequate staffing levels and allocations of resources to support programmatic needs.
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/06/1999	1998011	Pri: PLTSUP Sec:	NRC	POS	Pri: 2A Sec: 4A Ter: 4C	The Security System Design was Robust and therefore was Minimally Impacted by Winter Storms The security system design was robust and therefore was minimally impacted by the winter storms in early January. Compensatory measures taken were appropriate.
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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.