Beaver Valley 2
4Q/2008 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2008
Identified By: Self-Revealing
Item Type: FIN Finding
Deficient Control of Clearance Posting Interrupts Reactor Coolant Charging Path while Vessel Water Level Drained below the Flange.
A self-revealing finding was identified for failure to properly coordinate clearance activities associated with testing for penetration 2X-46 during reduced reactor coolant system (RCS) level. A decision to post a clearance to support penetration testing resulted in the isolation of the make-up flow charging path to the reactor coolant system, resulting in an unexpected reduction of reactor coolant vessel level that was identified and stabilized within the established band. The licensee's immediate corrective actions were to stop work, perform system configuration verification, and re-evaluated in-progress and planned activities for plant safety impact. Long-term corrective actions include a change in procedures to not allow this type of penetration test in this plant configuration.
The finding is more than minor because it affects the configuration control attribute of
the Initiating Events cornerstone and affects the shutdown equipment lineup needed for stable reactor vessel level control during reduced RCS level operations, a high risk evolution. The inspectors performed a Phase 1 SDP evaluation in accordance with IMC 0609, Appendix G, Attachment 1, Checklist 3, Pressurized Water Reactor Cold Shutdown and Refueling Operation with RCS Open and Refueling Cavity Level < 23'. The inspectors reviewed station drawings and records of reactor vessel level indication during the event. The inspectors determined that although make-up flow was momentarily isolated, reactor vessel level was maintained, sufficient indication existed, and no actual loss of RCS inventory occurred. Therefore, a Phase 2 quantitative assessment was not required and the issue screened to Green (very low safety significance).
The cause of this finding is related to the cross-cutting area of human performance, in that FENOC did not appropriately coordinate work activities for the existing plant conditions to ensure the operational impact on reactor vessel level while at a reduced water level was fully understood [H.3(b)]
Inspection Report# : 2008003 *(pdf)*

Significance: G Jun 30, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Properly Implement Operating Procedure during Plant Startup
A Green self-revealing NCV of TS 5.4.1.(a) was identified in that the licensee failed to take appropriate action to trip the main turbine as specified in 2OM-52.4.A, "Raising Power from 5% to Full Load Operation," Rev. 13 during an unexpected main turbine load increase that resulted in average reactor coolant temperature below the operational limit of 541F. The licensee has developed and implemented an operations department rapid improvement plan.
This finding was more than minor because it can be reasonably viewed as a precursor to a significant event. Traditional enforcement does not apply because the issue did not have an actual safety consequence or the potential for impacting NRC's regulatory function, and was not the result of any willful violation of NRC requirements. In accordance with Inspection Manual Chapter (IMC) 0609, Attachment 609.04, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low risk significance.
The cause of this finding is related to the cross-cutting area of human performance, in that FENOC failed to properly communicate critical parameters and limitations for personnel to perform work safely in a timely manner [H.1.(c)]
Inspection Report# : 2008003 *(pdf)*

Mitigating Systems

Significance: G Nov 24, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CORRECTIVE ACTION FOR POTENTIAL BLOCKAGE OF AFW PUMP LUBE OIL COOLING SYSTEM ORIFICES WHEN SUPPLIED BY RW/SW
The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action, in that FENOC did not take adequate corrective action following the identification of a condition adverse to quality. Specifically, in 2004, 2005 and 2006, FENOC identified that if the Unit 1 river water (RW) system or the Unit 2 service water (SW) system was aligned to the suction of the auxiliary feedwater (AFW) pumps it could result in blockage of cooling water flow for the pumps, but did not take actions to correct the deficiency. FENOC entered the issue into their corrective action program to correct the non-conformance. In addition, FENOC developed Operations Department standing orders to limit the use of TS action statement 3.7.6.a which credited the use of the lineup, and formalized compensatory actions to address an Appendix R compliance deficiency. The finding was more than minor because there was reasonable doubt as to the operability of the AFW system when supplied from RW or SW systems. In addition, the finding was associated with the design control attribute of the Mitigating Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Since the finding represented a potential loss of safety function, the team conducted Significance Determination Process (SDP) Phase 2 and Phase 3 analyses which determined the finding was of very low safety significance (Green). Finally, the finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program Component, because FENOC did not adequately evaluate this condition adverse to quality, including classifying, prioritizing, and evaluating for operability when it was identified in February 2004, and again in March 2005 and June 2006.

Inspection Report# : 2008008 *(pdf)*

Significance: G Jun 30, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Properly Implement Abnormal Operating Procedure During Plant Startup
A Green self-revealing NCV of TS 5.4.1.(a) was identified in that the licensee failed to properly enter and implement the appropriate abnormal operating procedure (AOP) for loss of main feedwater. The licensee has developed and implemented an operations department rapid improvement plan.
This finding was more than minor because it can be reasonably viewed as a precursor to a significant event. Traditional enforcement does not apply because the issue did not have an actual safety consequence or the potential for impacting NRC's regulatory function, and was not the result of any willful violation of NRC requirements. In accordance with Inspection Manual Chapter (IMC) 0609, Attachment 609.04, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low risk significance.
The cause of this finding is related to the cross-cutting area of human performance, in that FENOC failed to properly implement appropriate roles and authority for decision making during risk-significant decisions. [H.1.(a)]
Inspection Report# : 2008003 *(pdf)*

Significance: G Mar 31, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Incorrect performance of Test Procedure
A self-revealing, Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XI "Test Control," was identified for the failure to properly perform line starter testing for a Unit 2 safety-related battery exhaust fan (2HVZ-FN216B) in accordance with the written test procedure. The test procedure for the line starter establishes test conditions by installing jumpers into a process rack, RK-2SEC-PROC-B1. Due to misidentification, jumpers were installed into the incorrect process rack, RK-2SEC-PROC-B. This rendered the 'B' train of Quench Spray Chemical Additive System

inoperable for less than the allowed outage time. The licensee entered the deficiency into their corrective action program as Condition Report 08-37168. FENOC performed a root cause evaluation, evaluated appropriate human performance contributors, and initiated corrective actions to prevent recurrence. The finding is greater than minor because it affected the equipment performance attribute of the associated Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. This finding is also similar to example 4.b of Manual Chapter 0612, Appendix E. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance, because there was no overall loss of system function due to system redundancy and the system would have been able to perform its required safety function for the applicable mission time during design basis events. The cause of this finding is related to the cross-cutting area of human performance, in that FENOC failed to utilize adequate self and peer checking during the identification of equipment and circuits specified in the test plan [H.4(a].

Inspection Report# : 2008002 *(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Last modified : April 07, 2009