

# Beaver Valley 2

## 3Q/2011 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:**  Jun 30, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Maintain Recirculation Spray HXs in Chemical Wet Layup**

A Green, self-revealing non-cited violation (NCV) of TS 5.4.1, "Procedures", was identified in that the Unit 2 recirculation spray (RSS) HXs were not maintained in chemical wet layup, contrary to station procedures and industry guidance. Specifically, FENOC failed to place corrosion inhibitors in the RSS HXs, resulting in significant HX corrosion, which lead to degraded flow through the B RSS HX during a service water full flow test. This issue was entered into the licensee's corrective action program under CR 11-90430.

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. The inspectors determined that the finding was not similar to the examples for minor deficiencies contained in IMC 0612, Appendix E, "Examples of Minor Issues". The finding is more than minor because it affects the Mitigating Systems and Barrier Integrity cornerstones. The finding is associated with the equipment performance attribute of the Mitigating Systems cornerstone to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and is also associated with the SSC and barrier performance attribute of the Barrier Integrity cornerstone to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system and containment) protect the public from radionuclide releases caused by accidents or events.

In accordance with IMC 0609.04 (Table 4a), Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance (Green) because the finding did not result in a loss of operability, nor was it a degradation of a radiological barrier, control room barrier, hydrogen ignitor, or an open pathway.

The cause of this NCV relates to the cross-cutting aspect of Human Performance, Work Control, in that FENOC personnel did not plan and coordinate work activities consistent with nuclear safety. Specifically, FENOC did not plan and coordinate work activities to support long-term equipment reliability of the RSS HXs.[H.3(b)]

Inspection Report# : [2011003](#) (*pdf*)

**Significance:**  Jun 17, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

#### **INADEQUATE CALCULATIONS FOR PLACING SSST LTC IN MANUAL MODE**

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," because FENOC did not correctly translate the design basis of the electrical distribution system into procedures to ensure operability of offsite power during bus transfers when operating the system service station transformer (SSST) load tap changers (LTC) in the manual mode, an allowed system configuration. Specifically, the team found that procedure's supporting calculation did not

evaluate the voltage levels on the 480 volt buses. The team determined that during some design basis events, with the tap changer in manual, voltage on the 480 volt vital bus could degrade to a level that would cause the degraded grid relays to trip, resulting in a spurious trip of offsite power. FENOC entered the issue into the corrective action program, and implemented an Operation's night order to ensure the LTC was maintained in automatic. The team determined that the issue was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Design Control, and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance (Green) because it was a design deficiency confirmed not to result in a loss of operability or functionality. The team determined that there was not a crosscutting aspect associated with this finding because it was not indicative of current performance. Inspection Report# : [2011007](#) (pdf)

**Significance:**  Jun 17, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **OFFSITE POWER NON-CONSERVATIVE POST TRANSIENT VOLTAGE CALCULATIONS**

The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," because FENOC did not perform adequate voltage calculations to verify that vital bus voltage levels would be adequate when offsite power was the bus voltage source. The team determined that nonconservative assumptions and evaluations caused the calculation results to predict higher bus voltage levels than could actually occur. Specifically, the team found that FENOC's calculational assumptions related to the initial tap position of the SSSTs following bus transfers, evaluation of the effect of the voltage dips that occur during a fast bus transfer, and assumptions for the post event grid voltage condition following the main generator trip could be worse than assumed in the calculation. FENOC entered the issue into the corrective action program, and revised calculations and evaluated post event grid voltage conditions to verify the adequacy of the offsite power source.

The team determined that this issue was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Design Control, and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance (Green) because it was a design deficiency confirmed not to result in a loss of operability or functionality. The team determined that there was not a crosscutting aspect associated with this finding because it was not indicative of current performance.

Inspection Report# : [2011007](#) (pdf)

**Significance:**  Mar 07, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **INADVERTENT AUXILIARY FEEDWATER START DURING STEAM GENERATOR WATER LEVEL INSTRUMENT ADJUSTMENTS**

A Green, self-revealing non-cited violation (NCV) of TS 5.4.1, "Procedures", was identified in that technicians inadvertently caused an auxiliary feedwater actuation. Specifically, the procedure used was inadequately written to adjust steam generator water levels, which resulted in the technicians inserting 2/3 Low-Low level signals to the SGs and actuating auxiliary feedwater. This issue was entered into the licensee's corrective action program under CR 11-90528.

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. The finding is more than minor because it is similar to example 4.b in IMC 0612, Appendix E.

The inspectors performed a Phase 1 SDP evaluation in accordance with IMC 0609, Appendix G, Attachment 1,

Checklist 2 “PWR Cold Shutdown Operation: RCS Closed and SGs Available for DHR (Loops Filled and Inventory in Pressurizer) Time to Boiling Less than 2 Hours.” There was no loss of control, and all mitigating capabilities were available, therefore a Phase 2 quantitative assessment was not required and the issue screened to Green (very low safety significance).

The cause of this NCV relates to the cross-cutting aspect of Human Performance, Work Control, in that FENOC personnel did not appropriately coordinate work activities by incorporating actions to address the need to communicate, coordinate and cooperate with each other during activities in which interdepartmental coordination is necessary to assure plant and human performance.[H.3.(b)]

Inspection Report# : [2011002](#) (*pdf*)

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

**Significance:**  Jun 30, 2011

Identified By: NRC

Item Type: FIN Finding

### Untimely Radiation Monitor Corrective Actions

A Green, NRC identified finding (FIN) was identified in that plans and actions to correct long-standing radiation monitor system instrumentation deficiencies were not accomplished in a timely manner, in accordance with FENOC CAP procedure NOP-LP-2001. Specifically, FENOC failed to correct and return to service radiation monitor instruments for the Unit 1 and Unit 2 RSS HX [RM-1RW-100A,B,C,D and 2SWS-RQ100A,B,C,D], in a timely manner, requiring maintenance of alternate monitoring and challenges to assessing radiation detection and assessment during accident situations. This issue was entered into the licensee’s corrective action program under CR(s) 11-91673 and 11-89700.

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. The inspectors determined that the finding was not similar to the examples for minor deficiencies contained in IMC 0612, Appendix E, “Examples of Minor Issues”. The finding is more than minor because it affects the Public Radiation Safety cornerstone. The finding is associated with the attribute of plant equipment and instrumentation (process radiation monitors) attribute of the Public Radiation Safety cornerstone to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain as a result of routine civilian nuclear reactor operation.

In accordance with IMC 0609.04 (Table 3a), “Phase 1 – Initial Screening and Characterization of Findings,” the finding was evaluated using IMC 0609 Appendix D, “Public Radiation Safety Significance Determination Process” and determined to be of very low safety significance (Green) because the finding was not a failure to implement the effluent program or cause any public dose to be exceeded.

The cause of this NCV relates to the cross-cutting aspect of Problem, Identification, and resolution, Corrective Action

Program, in that FENOC personnel did not take timely corrective actions to develop and implement actions for long-standing radiation monitor deficiencies. [P.1(d)] (Section 40A2)

Inspection Report# : [2011003](#) (*pdf*)

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## 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.

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## Miscellaneous

Last modified : January 04, 2012