Beaver Valley 2
2Q/2012 Plant Inspection Findings

Initiating Events

Significance: G Sep 16, 2011
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Implement Corrective Actions for 2A Service Water Pump Motor Epoxy Vioding
The inspectors identified a Green , self-revealing, non-cited violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action," in that FENOC did not take corrective actions to prevent recurrence of a significant condition adverse to quality. Specifically, FENOC failed to implement corrective actions following the 2A service water pump motor failure in 2005, which resulted in another failure of the same pump motor in 2011. FENOC implemented the corrective actions to prevent recurrence identified following the 2005 failure for the rewind of 2SWS-P21A motor in July 2011. FENOC documented this issue in their corrective action program as condition report 11-96293.

The inspectors determined that FENOC's failure to prevent recurrence of a significant condition adverse to quality was a performance deficiency. Specifically, FENOC failed to implement corrective actions to prevent recurrence of a turn-to-turn winding failure of the 2A service water pump due to excessive voiding in the epoxy of the stator end windings. This self-revealing finding is more than minor because it was associated with the equipment performance attribute of the Initiating Events cornerstone and adversely impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," for the initiating events cornerstone. The inspectors determined that the finding was of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or function would be unavailable. The inspectors determined that this finding had no cross cutting aspect because it is not reflective of current plant performance. Specifically, the actual performance deficiency occurred in 2005 and FENOC implemented corrective actions from the 2005 root cause evaluation for the 2011 rewind of the 2A service water pump motor.

Inspection Report# : 2011009 *(pdf)*

Mitigating Systems

Significance: G Sep 16, 2011
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to lmplement Effective Corrective Actions to Prevent Recurrence of Socket-Weld Failures
The inspectors identified a Green, self-revealing, non-cited violation of 10 CFR 50, Appendix B, Criterion XVl, "Corrective Action," in that FENOC failed to take adequate corrective actions to prevent recurrence of a significant condition adverse to quality. Specifically, FENOC's extent of condition review and long-term corrective actions following a residual heat removal socket weld failure, caused by vibration-induced high-cycle fatigue, were inadequate to preclude the recurrence of a similar failure on the auxiliary feedwater system. FENOC entered this issue into their corrective action program as condition report 11-01453 for further review.

The inspectors determined that FENOC's failure to plan or implement adequate corrective actions to prevent recurrence of socket weld failures on safety-related piping was a performance deficiency. This issue was reasonably within FENOC's ability to foresee and correct due to previous opportunities to identify and correct socket weld

failures on safety-related systems at Beaver Valley. The inspectors determined that this self-revealing finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The inspectors evaluated the significance of this finding using IMC 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," and determined that this finding was of very low safety significance (Green) because the finding was not a design or qualification deficiency, did not represent a loss of safety system function, and did not screen as potentially risk-significant due to external initiating events. This finding had a cross-cutting aspect in the area of problem identification and resolution because FENOC did not thoroughly evaluate a significant condition adverse to quality such that the resolutions address the extent-of-condition. Specifically, FENOC failed to perform an adequate extent of condition review following the failure of the 1RH-200 socket weld which resulted in not developing adequate corrective actions to address socket welds on the auxiliary feedwater system.[P.1(c)]
Inspection Report# : 2011009 *(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: G Oct 25, 2011
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
UNANNOUNCED EMERGENCY RESPONSE ORGANIZATION ACTIVATION DRILL FAILURE
A Green, self-revealing non-cited violation (NCV) of 10 CFR 50.47(b)(2) to ensure timely augmentation of response capabilities is available was identified. Specifically, FENOC failed to fully staff two primary Emergency Response Organization (ERO) positions during an unannounced activation drill. This issue was entered into the licensee's corrective action program under CR 2011-04431.

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 Emergency Preparedness cornerstone. The finding is associated with the ERO readiness attribute of the Emergency Preparedness cornerstone to ensure that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency.

In accordance with IMC 0609, Appendix B, Sheet 1, "Failure to Comply" flowchart, the performance deficiency screens to green because it is considered a degraded planning standard function.

The cause of this NCV relates to the cross-cutting aspect of Human Performance, Work Practices, in that FENOC personnel did not effectively communicate expectations regarding drill participation and staff did not respond in the required time for ERO positions they had accepted in the call out system [H.4(b)].

Inspection Report# : 2011005 *(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Last modified : September 12, 2012