

Beaver Valley 1 4Q/2015 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: FIN Finding

Failure to Correct a Low Oil Level in the Condensate Pump Motor

A self-revealing finding was identified for FENOC's failure to correct a low oil level in the lower motor bearing of the Unit 1 'A' condensate pump in accordance with NOP-LP-2001, "Corrective Action Program." Specifically, FENOC incorrectly cancelled the work order to add oil to the 'A' condensate pump motor and installed a placard on the oil level sight glass with incorrect minimum and maximum oil levels. This led to the motor bearing failure, which caused the pump to trip on overcurrent, and required the operators to insert a manual reactor trip. FENOC entered the issue into their correct action program, condition report (CR) 2015-05256.

The performance deficiency was more-than-minor because it was associated with the human performance attribute of the Initiating Events cornerstone, and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, NOP-LP-2001, section 4.2.3, states that condition report/correct action owners should ensure that actions are developed to resolve the primary cause identified in the condition report. Instead of correcting the low oil level in the motor, FENOC cancelled the work order to add oil. This subsequently caused the operators to trip the plant when the condensate pump motor bearing overheated and the motor tripped on overcurrent. The inspectors determined that this finding was of very low safety significance (Green) because it did not cause a reactor trip and the loss of mitigation equipment. This finding has a cross-cutting aspect in the area of Human Performance, Consistent Process, because FENOC did not seek input from the appropriate work group (engineering) prior to cancelling the work order to add oil to the condensate pump motor. [H.13]

Inspection Report# : [2015003](#) (*pdf*)

Significance:  Jun 26, 2015

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Initiate a Condition Report for an Adverse Condition

Green. A Green self-revealing finding of NOP-LP-2001, "Corrective Action Program," was identified after FENOC failed to generate a condition report for a condition adverse to quality. Specifically, FENOC did not initiate a condition report when a lifted lead was identified during preventative maintenance and installation of the Unit 1 main transformer. As a result, corrective actions were not taken and this led to an unplanned downpower from 100 percent to 15 percent reactor power on January 31, 2014.

The performance deficiency was more-than-minor because it was associated with the Equipment Performance attribute of the Initiating Events cornerstone, and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. This finding was determined to be of very low safety significance (Green), because it did not cause a reactor trip and the loss of mitigation equipment. This finding has a

cross-cutting aspect in the area of Human Performance, Field Presence, because FENOC failed to ensure supervisory and management oversight of work activities, including contractors and supplemental personnel. [H.2]
Inspection Report# : [2015008](#) (pdf)

Mitigating Systems

Significance:  Aug 21, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unanalyzed Condition Resulting from Unfused Direct Current Control Circuits

On April 30, 2014, FENOC identified a violation of very low safety significance of 10 CFR 50, Appendix R, Section III.G for BVPS Unit 1 in that unfused direct current (DC) control circuits for DC motors were routed from the turbine building through other fire areas. The DC breakers used to protect the motor power conductors were insufficient to protect the control conductors for these circuits and it is postulated that a fire induced short in one fire area could adversely impact safe shutdown equipment by overheating the cable and causing a secondary fire in other fire areas where the cable is routed. The team identified that FENOC did not establish a fire watch in one of the affected fire areas, the turbine building, as a compensatory measure. Therefore, because FENOC did not initiate immediate corrective action or compensatory measures or both within a reasonable time, enforcement discretion will not be exercised. This violation will be treated as a NRC-identified violation. In response to the NRC finding, FENOC promptly initiated a one hour roving fire watch patrol in the turbine building. The lack of compensatory measures in the turbine building occurred because administrative procedure, 1/2-ADM-1900, Fire Protection Program, used to determine compensatory measures for fire protection program deficiencies, was inadequate in its guidance to plant personnel for review of cable separation issues. For cable separation issues, 1/2-ADM-1900 required fire watches in only one of two affected adjacent fire areas. FENOC entered this issue into its corrective action program as condition report (CR) CR-2015-10546 and planned to revise 1/2-ADM-1900 to ensure fire watches were established in all affected fire areas that involved cable separation issues. FENOC initiated CR-2014-07961 to resolve the DC circuit non-conformance using National Fire Protection Association (NFPA) 805 performance based fire risk evaluations considering the low probability of a secondary cable fire due to overheating of cables associated with the pump motor control circuits during an electrical fault condition with no circuit protection.

This finding was more than minor because it adversely affected the protection against external factors (i.e., fire) attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences.

FENOC reviewed the cable routes and evaluated this issue through use of its fire probabilistic risk assessment (PRA). FENOC determined that the change in core damage frequency attributed to the issue for Unit 1 was $8.5E-7$ per reactor year. NRC staff reviewed this evaluation and concluded that the risk numbers were bounded by conservative assumptions and that this issue would be of very low safety significance. This finding had a cross-cutting aspect in the area of Human Performance, Resources, because FENOC did not ensure that procedures were adequate to support nuclear safety. Specifically, 1/2-1900-ADM was too restrictive for safe shutdown circuit separation issues in that it mandated an hourly fire watch patrol in only one of the two adjacent fire areas and for this issue FENOC did not appropriately establish an hourly fire watch patrol in the Unit 1 turbine building. [H.1]

Inspection Report# : [2015007](#) (pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Utilize Respiratory Protection as Specified by the Radiation Work Permit

• Green. The inspectors identified a self-revealing NCV of Technical Specification 5.4.1, “Procedures,” for FENOC’s failure to utilize respiratory protection, as required by the applicable radiation work permit (RWP), for entry into the 722-foot elevation of the solid radioactive waste building on March 12, 2014. This resulted in the unplanned internal exposure of one worker. Immediate corrective actions included reestablishing RWP controls of the area and entering this issue into their corrective action program as condition report 2015-06636.

The inspectors determined that the performance deficiency is more than minor because it affected the Program and Process attribute of the Occupational Radiation Safety cornerstone objective to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The inspectors evaluated the finding using NRC Inspection Manual Chapter 0609, Appendix C, “Occupational Radiation Safety Significance Determination Process,” and determined the finding to be of very low safety significance (Green) because it was not related to as low as (is) reasonably achievable (ALARA), did not result in an overexposure or a substantial potential for overexposure, and did not compromise the licensee's ability to assess dose. The finding has a cross-cutting aspect of Human Performance, Conservative Bias, in that individuals did not use decision making-practices that emphasized prudent choices over those that are simply allowable. Specifically, a radiation protection technician did not use conservative decision making practices and make prudent choices when entering an area with unknown radiological conditions. Examples of non-conservative decision making included: failure to wear respiratory protection when entering into unknown radiological conditions, the failure to complete and evaluate an air sample prior to entry, and not taking into account the adverse radiological conditions of the adjoining area above (735 foot elevation). [H.14]

Inspection Report# : [2015002](#) (*pdf*)

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 : March 01, 2016