

Beaver Valley 2

3Q/2016 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Identify Conditions Adverse to Quality Leads to Inoperable Emergency Bus Degraded Voltage Relays

The inspectors identified a Green NCV of Title 10 Code of Federal Regulations (CFR) 50, Appendix B, Criterion XVI, "Corrective Action," for FENOC's failure to assure that a condition adverse to quality was promptly identified and corrected. Specifically, FENOC failed to promptly identify and correct a negative trend in setpoint drift and "as found" dropout voltage values in the AB 27N model 411T6375HF 4160 volts alternating current (VAC) and 480 VAC emergency bus degraded voltage relays. FENOC's immediate corrective actions included recalibrating or replacing the relays and entering the issue into their corrective action program (CAP) as condition report (CR) 2016-12018.

The performance deficiency is more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, FENOC's failure to promptly identify and address a negative trend in dropout voltage setpoint drift and "as found" values resulted in the reduced reliability of safety related bus degraded voltage relays (seven surveillance failures and inoperable degraded bus relays between 2011 and 2016). Inoperable emergency bus degraded voltage relays could lead to damage of safety-related equipment during a loss of offsite power. This finding is of very low safety significance (Green) because it does not represent a loss of system and/or function, an actual loss of function of a single train for greater than its technical specification allowed outage time, an actual loss of function of one non-technical specification trains designated as high safety significant, and did not involve a loss or degradation of equipment designed to mitigate a seismic, flooding, or severe weather initiating event. The finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Trending, because FENOC did not periodically analyze the results of the degraded voltage relay surveillances to provide early indication of a declining trend. [P.4].

Inspection Report# : [2016003](#) (*pdf*)

Significance: G Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Procedure Change Results in Failure to Maintain the Design Basis for the Service Water System

Green. The inspectors identified an NCV of Title 10 of the Code of Federal Regulations (CFR) 50, Appendix B, Criterion III, "Design Control," for FENOC's failure to assure that the regulatory requirements and design basis for the Unit 2 service water system were correctly translated into procedures. Specifically, FENOC implemented a procedure revision in 2002 that inappropriately removed the step to declare the Unit 2 service water system inoperable while the non-seismic standby service water system is aligned to it. FENOC's immediate corrective actions included

issuing instructions that prohibit planned testing of or swapping to the standby service water system and revising procedure 2OST-30.1A. FENOC entered the issue into their CAP as condition report (CR) 2016-01710.

The performance deficiency is more-than-minor because it is associated with the Design Control attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, FENOC's revision to 2OST-30.1A in 2002 resulted in reduced reliability of the service water system while connected to the standby service water system for over ten hours on February 1, 2016, and nine hours on April 3, 2014. This finding was of very low safety significance (Green) because it did not represent a loss of system and/or function, an actual loss of function of a single train for greater than its technical specification allowed outage time, an actual loss of function of one non-technical specification trains designated as high safety significant, and did not involve a loss or degradation of equipment designed to mitigate a seismic, flooding, or severe weather initiating event. This finding does not have a cross-cutting aspect because it is not representative of current performance. The inadequate review of revision 17 to 2OST-30.1A was an isolated instance that occurred over 14 years ago. Furthermore, the most recent NRC inspection of Changes, Tests, or Experiments and Permanent Plant Modifications, performed in 2013, and the Component Design Basis Inspection, performed in 2014 did not document any findings related to procedure changes.

Inspection Report# : [2016002](#) (pdf)

Barrier Integrity

Emergency Preparedness

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Compensatory Measures to Ensure the Effectiveness of an EAL

Green. The inspectors identified a NCV of 10 CFR 50.54(q)(2) for FENOC's failure to follow and maintain the effectiveness of an emergency plan that meets the planning standards of 10 CFR 50.47(b)(4). Specifically, following the failure of the area radiation monitor for the Unit 2 primary auxiliary building 773' elevation on April 23, 2016, FENOC did not establish adequate compensatory measures to ensure the effectiveness of the emergency action level (EAL) for loss of control of radioactive material, RU2. FENOC's immediate corrective actions included establishing appropriate compensatory measures for RU2, communicating the standards of EAL compensatory measures to radiation protection technicians verbally and via narrative logs, and entering this issue into their CAP as CR 2016-05975.

The performance deficiency is more-than-minor because it is associated with the Facilities and Equipment attribute of the Emergency Preparedness cornerstone, and adversely affected the cornerstone objective to ensure that FENOC is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. This finding was determined to be of very low safety significance (Green) since it was example of an ineffective EAL, such that a notification of unusual event (NOUE) would not be declared or would be declared in a degraded manner. This finding has a cross-cutting aspect in Human Performance, Documentation, because FENOC did not ensure that plant activities are governed by comprehensive procedures [H.7]

Inspection Report# : [2016002](#) (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.

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Miscellaneous

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