

Beaver Valley 2 3Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2015

Identified By: NRC

Item Type: FIN Finding

Failure to Perform Maintenance in Accordance with Licensee Maintenance Process

• Green. A self-revealing finding was identified for FENOC's failure to perform maintenance on the Unit 2 feedwater heater drain system in accordance with FENOC's maintenance process, NOP-WM-4006, "Conduct of Maintenance." Specifically, FENOC did not adjust the 'A' first point feedwater heater normal and high level control valve (LCV) controllers to their specified setpoints. As a result, the 'A' heater and separator drain pumps tripped and this led to an unplanned power reduction from 100 percent to 60 percent reactor power on April 12, 2015. FENOC's corrective action included adjusting the setpoints of the LCV controllers to their specified setpoints and entering the issue into their corrective action program as condition report 2015-05088.

The performance deficiency was more-than-minor because it was associated with the Configuration Control 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. Additionally, the performance deficiency was similar to example 4.b in IMC 0612 Appendix E, in that failing to follow procedure caused a reactor transient. 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, Training, because FENOC failed to ensure knowledge transfer to maintain a knowledgeable, technically competent workforce and instill nuclear safety values. Specifically, FENOC did not ensure that knowledge was adequate to perform maintenance on the 'A' first point feedwater heater LCVs [H.9] Inspection Report# : [2015002](#) (*pdf*)

Mitigating Systems

Significance: G Dec 04, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Green NCV

The Commission has decided that specific information related to findings and performance indicators pertaining to security 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.

Inspection Report# : [2014007](#) (*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

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

FAILURE TO PROPERLY SHIP CATEGORY 2 RADIOACTIVE MATERIAL

The inspectors identified an NCV of 10 CFR 71.5, “Transportation of licensed material,” and 49 CFR 172, Subpart I,

“Safety and Security Plans.” Specifically, FENOC personnel shipped a category 2 radioactive material of concern (RAM-QC) on public highways to a waste processor without adhering to a transportation security plan. FENOC’s corrective actions included revising procedure NOP-OP-5201, “Shipment of Radioactive Material – Waste,” to reflect the appropriate Department of Transportation requirements for shipment of Category 2 radioactive material. FENOC entered the issue into their corrective action program as CR 2014-17260.

The issue is more than minor because it is associated with the Program and Process attribute of the Public Radiation Safety cornerstone and adversely affected its objective to ensure the safe transport of radioactive material on public highways in accordance with regulations. The finding was determined to be of very low safety significance (Green) because FENOC had an issue involving transportation of radioactive material, but it did not involve: (1) a radiation limit that was exceeded; (2) a breach of package during transport; (3) a certificate of compliance issue; (4) a low level burial ground nonconformance; or (5) a failure to make notifications or provide emergency information. The inspectors determined that the finding did not have a cross-cutting aspect because the issue was not reflective of current plant performance. Specifically, FENOC implemented changes to the radioactive waste shipment procedure that addressed applicable requirements and implemented a formal process for reviewing pending regulatory changes for impacts to FENOC operations and support activities.

Inspection Report# : [2014005](#) (*pdf*)

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

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