September 6, 2001

Mr. L. W. Myers
Senior Vice President
FirstEnergy Nuclear Operating Company
Beaver Valley Power Station
Post Office Box 4
Shippingport, Pennsylvania 15077

SUBJECT: BEAVER VALLEY POWER STATION - NRC INSPECTION REPORTS 50-334/01-011; 50-412/01-011

Dear Mr. Myers:

On July 27, 2001, the NRC completed a team inspection at the Beaver Valley Power Station, Units 1 & 2. The enclosed report presents the results of that inspection. The results of the inspection were discussed with Mr. L. Pearce and other members of your staff on July 27, 2001.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection consisted of a selected examination of procedures and representative records, observations of activities, and interviews with personnel.

The team concluded that in general, problems were properly identified, evaluated and corrected. However, the team identified one finding of very low safety significance (Green) associated with an inadequate evaluation involving molded case circuit breakers in safety related applications. This issue was determined to involve violation of NRC requirements. However, because of the very low safety significance, and because the issue was entered into your corrective action program, the NRC is treating this issue as a Non-Cited Violation, consistent with Section VI.A.1 of the NRC Enforcement Policy. If you deny this Non-Cited Violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Beaver Valley Station.

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Sincerely,

/RA/

Wayne D. Lanning, Director
Division of Reactor Safety

Docket Nos.: 50-334; 50-412
License Nos: DPR-66, NPF-73

Enclosure:
Inspection Report 50-334/01-011; 50-412/01-011

cc w/encl:
L. W. Pearce, Plant General Manager
R. Fast, Director, Plant Maintenance
F. von Ahn, Director, Plant Engineering
R. Donnellon, Director, Projects and Scheduling
M. Pearson, Director, Nuclear Services
T. Cosgrove, Manager, Nuclear Regulatory Affairs
J. A. Hultz, Manager, Projects and Support Services, FirstEnergy
M. Clancy, Mayor, Shippingport, PA
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NAME	A DellaGreca		D Lew		J Rogge		J Trapp***/JTS for***		W Lanning/RVC for	
DATE	9/05/01		09/06/01		09/05/01		09/05/01		09/06/01	

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U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket Nos.:	50-334, 50-412
License Nos.:	DPR-66, NPF-73
Report Nos.:	50-334/01-011, 50-412/01-011
Licensee:	First Energy Nuclear Operating Company
Facility:	Beaver Valley Power Station, Units 1 and 2
Location:	Post Office Box 4 Shippingport, PA 15077
Dates:	July 9, 2001 through July 27, 2001
Inspectors:	A. Della Greca, Senior Reactor Inspector, DRS M. Buckley, Susquehanna Resident Inspector, DRP T. Burns, Reactor Inspector, DRS F. Jaxheimer, Reactor Inspector, DRS
Approved by:	David C. Lew, Chief Performance Evaluation Branch Division of Reactor Safety

SUMMARY OF FINDINGS

IR 05000334/01-011 and 05000412/01-011, on 7/9-7/27/2001; Beaver Valley Power Station, Units 1 & 2; annual baseline inspection of the identification and resolution of problems.

The inspection was conducted by two regional inspectors and a resident inspector. The inspection identified one finding which was determined to be of very low safety significance (Green) and categorized as a Non-Cited Violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html.

Identification and Resolution of Problems

The licensee's performance in the area of problem identification and resolution was acceptable. The licensee was appropriately identifying problems and entering them into their corrective action process. Condition reports (CRs) received an adequate level of review, and when a root cause analysis was performed, the evaluations were generally thorough and adequate. Notwithstanding, the team identified that the licensee did not evaluate molded case circuit breaker test failures in sufficient detail to identify the causes of the problem and, therefore, did not provide for corrective actions to prevent recurrence. The team also identified an instance where an evaluation of a recirculation spray system flow sensing line refill interval was not technically well supported. The licensee's corrective actions were adequate to correct the identified problem and prevent recurrence. Current trends indicate a large increase in the backlog of open condition reports and corresponding corrective actions. This increase is primarily the result of the licensee's lowering of the threshold for initiating CRs.

Cornerstone: Mitigating Systems

GREEN. A Non-Cited Violation of 10 CFR 50 Appendix B, Criterion XVI was identified for failure to assure the cause of safety related molded-case circuit breaker (MCCB) test failures was identified and corrective actions taken to preclude recurrence. Two safety-related MCCBs, which had been removed from service several years ago, failed during recent testing. However, the licensee did not initiate a condition report to assure the cause would be identified and appropriate corrective actions would be taken. The MCCB test failures are significant because many MCCBs in safety-related applications were installed during initial plant construction and have not been subject to a periodic testing program.

The issue affects the mitigating systems cornerstone because the problem could affect the operability and availability of mitigating systems. However, because the two breakers that failed the test acceptance criteria had already been removed from safety-related applications and were currently spares, there was no actual loss of safety function. For the MCCBs that were in service, the licensee's evaluation determined them to be operable. Consequently the finding is considered to be of very low safety significance (Green). Because the finding is of very low safety significance and is being addressed with the licensee's corrective action process, this finding is being treated as a Non-Cited Violation, consistent with Section VI.A.1 of the NRC Enforcement Policy. (Section O4A2.2)

Report Details

4. OTHER ACTIVITIES [OA]

4OA2 Identification and Resolution of Problems

.1 Effectiveness of Problem Identification

a. Inspection Scope

The team evaluated selected maintenance work orders, operator work-around items, temporary modifications, maintenance and engineering backlogs, security logs and radiation event logs to determine whether the licensee was appropriately considering problems identified in these processes for entry into their corrective action, or condition report process (CRP). These documents are listed in Attachment 1. The team also reviewed selected operating experience reports and event notifications and conducted plant walkdowns to ensure problems were being identified. The team also interviewed the plant staff and management to assess the scope and effectiveness of the licensee's use of the CRP to identify plant and human performance issues.

The team further reviewed Quality Assurance (QA) audit and surveillance reports, departmental self-assessments, and third-party reviews of licensee performance to determine whether problems identified from these activities were considered for entry into the CRP.

b. Issues and Findings

The team determined that the licensee, with minor exceptions, was properly identifying problems and entering them into their CRP. The team observed the program was widely accepted among the plant staff to document problems. The team further observed that the program was being properly used to identify problems and issues resulting from operating experience reviews, QA audits, surveillance reports, self assessments, and ongoing system reviews. The team also observed that the licensee appropriately used the CRP to identify and correct negative trends.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The team reviewed the condition reports (CRs) listed in Attachment 1 to assess the appropriateness of the licensee's classification of the significance level, cause determination, and the extent of condition review. The team further assessed the licensee's review of the CRs for operability, reportability, and Maintenance Rule reliability and unavailability. The licensee's corrective action, maintenance and engineering backlogs were also reviewed to determine if corrective actions, individually or collectively, represented an increased risk due to the delay of implementation. The team further observed the Corrective Action Review Board (CARB) proceedings during the inspection to evaluate the adequacy of management reviews with respect to the root cause evaluation and the proposed corrective actions.

The team observed the licensee's CRP provided for three CR levels based on the significance of the problem being evaluated. Within these levels the CRP allowed for different types of evaluations, ranging from a simple apparent cause determination to an extensive root cause evaluation performed by a multi-disciplinary team. For problems classified as significant conditions adverse to quality (SQAC), one of the three most detailed types of evaluation were required. For less significant problems classified as either conditions adverse to quality (CAQ) or conditions not adverse to quality (NCAQ), as many as six types of evaluations were permitted based on the risk impact.

b. Issues and Findings

Based on the CR sample selected, the team determined CRs generally received an adequate level of review. When a root cause analysis was performed, the licensee's evaluation was normally thorough and adequate. The team further concluded the licensee's CARB review of significant CR problem evaluations was thorough. Notwithstanding, the team identified one instance regarding molded-case circuit breaker test failures where the licensee did not evaluate the failures in sufficient detail to identify the causes of the problem and, therefore, did not provide for corrective actions to prevent recurrence. The team also identified an instance where the evaluation of a recirculation spray system flow sensing line refill interval was not technically well supported.

The team concluded the licensee staff adequately considered operability and reportability requirements associated with problems; however, the team identified occasional examples where the bases for operability were not fully developed.

With regard to classification of problems, the team determined that CRs were generally classified at the correct significance level. One instance was identified where the work-around status of a demineralizer automatic bypass valve was not factored into the CR categorization. Specifically, the demineralizer automatic bypass valve TCV-CH-143 was inoperable and it was not possible to bypass the letdown demineralizers either automatically on high temperature or manually from the control room. This condition required an operator to be dispatched to isolate the demineralizer line locally; however, it was not identified as an operator workaround condition and processed according to the licensee‘s procedure for workaround conditions. For this example, the team concluded the evaluation of the problem in the CR was adequate.

Molded-Case Circuit Breakers

Green. A non-cited violation of 10 CFR 50, Appendix B, Criterion XVI for failure to assure the cause of MCCB test failures was identified and corrective actions taken to preclude recurrence. The licensee did not evaluate molded-case circuit breaker (MCCB) test failure results in April 2001 to determine the cause of the problem and take prompt corrective actions to preclude repetition. Also the licensee's response to several years of industry experience indicating problems with MCCBs was not timely, and the postponement of testing of Beaver Valley (BV) Unit 1 MCCBs until January 2002 was not technically well supported. The MCCB test failures were significant because many MCCBs installed during plant construction in safety-related applications have not been subject to a periodic

testing program, and industry experience has previously shown age related problems with MCCBs. MCCB aging could result in safety-related equipment not functioning when called upon.

The licensee initiated CR 00-2262 on August 8, 2000, to test MCCBs of both BV Units. These MCCBs had not undergone surveillance, periodic operational exercising, or preventive maintenance testing, since they were installed in the plant, most of them prior to the plant commercial operation. Industry operating experience, as described in NRC Information Notices 93-26 and 93-64, and 99-13, has shown that MCCBs can degrade over time and periodic testing is prudent. CR 00-2262 had been issued to develop a testing program for the MCCBs. Because the CR was intended to develop a test program, a lower evaluation category was assigned to the CR as allowed by the licensee's CRP procedure.

The licensee planned to test ten MCCBs from each BV Unit. The results of these tests would then be used to develop the scope and frequency of the MCCB preventive maintenance program. After several postponements, the licensee tested ten Unit 2 breakers in April and May 2001. The breakers included two safety-related MCCBs that had been removed from service several years ago and eight additional nonsafety-related MCCBs. The team determined, through discussions with the cognizant system engineer, that the eight non safety-related MCCBs had met the test acceptance criteria, but both safety-related MCCBs had failed to meet the test criteria. Specifically, on April 26, 2001, when Phase A of the first breaker was subjected to 300 percent of its current rating the breaker tripped open and would not reset. On May 3, 2001, when the second breaker was subjected to rated current, it tripped open after less than nine of the sixty minutes required by the licensees test procedure, 1/2CMP-75-MCB-2E.

As a result of the test failures, the two safety-related breakers were not available as spare parts. The licensee subsequently postponed testing of the BV Unit 1 MCCBs until January 31, 2002, due to MCCB spare parts issues. The team determined that the licensee did not initiate a CR to evaluate the test results or evaluate the results under CR 00-2262, which tracked development of a MCCB testing program. Following the inspection, the licensee evaluated the issue and provided their bases for reasonable assurance that the approximately 500 safety-related circuit breakers affected by the issue were operable and capable of performing their safety function. The licensee also initiated plans to conduct further tests and replace the more critical MCCBs. The team concluded the licensee did not fully evaluate the two safety-related MCCB test results to assure the cause of the MCCB test failures was identified and corrective actions taken to preclude recurrence.

The finding was reviewed through the Significant Determination Process (SDP) Phase 1 screening and found to be more than minor since the test results could reasonably be viewed as precursor to a significant event. Specifically, the test results indicated the potential for degradation of the MCCBs installed in safety-related applications in the plant. Degradation of the MCCBs affects the mitigating system cornerstone because the problem could affect the operability and availability of mitigating systems. However, because the two breakers that failed the test acceptance criteria had already been removed from their safety-related application for several years and were currently spares, there was no actual

loss of safety function. Consequently the finding is considered to be of very low safety significance (green). 10 CFR 50, Appendix B, requires, in part, that for significant conditions adverse to quality, measures shall assure the cause of the condition is determined and corrective actions are taken to preclude recurrence. Contrary to this requirement, the licensee did not evaluate molded-case circuit breaker test failure results in April 2001 to determine the cause of the problem and take corrective actions to preclude repetition. However, because of the very low safety significance of the issue and because the licensee included this item in their Corrective Action Program (CR 01-4653), this issue is being treated as a Non-Cited Violation. **(NCV 50-334; 412/01-011-01)**

Recirculation Spray System Flow Instrumentation

The team determined the licensee's evaluation of a recirculation spray system (RSS) indicated flow accuracy problem did not provide a well supported justification for increasing the refill interval of flow sensing lines. However, during the inspection the licensee provided additional information to show that the resulting maximum flow error would be minimal.

The licensee initiated CR 00-2938 to evaluate possible modifications of the sensing line to eliminate an operator workaround condition. The RSS is a four-loop post-accident mitigating system used for containment spray and to recirculate water from the sump into the reactor through the safety injection system. During normal operation the system piping is dry. However, the flow transmitters at the pump discharge use liquid-filled sensing lines that are open to the atmosphere. The licensee concluded the heat and sub-atmospheric conditions in the reactor building during normal plant operation cause the liquid in the sensing line to evaporate partially and the flow instrument to provide flow indication during no flow conditions. CR 00-2938 specifically addressed the RSS loop D flow transmitters, which indicated a flow of 700 gpm with no flow in the system. Other RSS instruments indicated negative flow at no flow conditions. All four instrument loops were affected by the condition.

The issue had been evaluated previously, with a corrective action to refill the sensing lines on a monthly basis. Recently the refilling period was extended to three months based on a previous analysis which concluded that, during pump operation, the sensing lines would fill and read correctly. The team concluded that during pump operation air would be remain trapped in the sensing lines and that the instruments would continue to read incorrectly. This was corroborated by flow measurements taken during previous system testing. Therefore, the team considered the increase of the sensing line refill interval to be unjustified. During the inspection, the licensee provided a preliminary analysis that indicated that during post-accident system performance requirements (approximately 3500 gpm flow), the differential pressure that caused an erroneous indication of 700 gpm at no flow conditions would result in an indicated flow error of approximately 2 percent and, hence, within typical instrument loop accuracies. Based on these results, the team concluded the flow error resulting from the increased sensing line refill interval would not affect RSS operation and, therefore, did not meet the Group 1 screening criteria for evaluation with the SDP. However, the licensee's initial evaluation of this condition was not well justified.

3. Effectiveness of Corrective Actions

a. Inspection Scope

The team reviewed the corrective actions associated with the Beaver Valley cause evaluations to determine the status of the actions and the effectiveness of the actions to preclude recurrence.

b. Issues and Findings

The team determined that the actions identified on the CRs were generally adequate to correct the identified problem and, as appropriate, to prevent recurrence. Corrective action prioritization and timeliness were reasonable, although the team identified occasional examples where a corrective action was deferred by developing new corrective actions or new CRs.

The team also reviewed the corrective actions associated with the backlog of maintenance and engineering issues, and determined that the backlogs were properly prioritized. The team observed that current trends indicate a large increase in the backlog of open CRs with a corresponding increase in the backlog of scheduled or in-progress corrective actions. This increase was primarily the result of the licensee's lowering of the threshold for initiating CRs.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The team interviewed plant personnel to determine if personnel were hesitant to identify safety issues.

b. Issues and Findings

There were no findings identified during this inspection.

4OA6 Meetings, Including Exit

Exit Meeting Summary

The team presented the inspection results to Mr. L. Pearce and other members of licensee management, at the conclusion of the inspections on July 27, 2001. The team asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

Attachments:

Partial List of Personnel Contacted
Items Opened, Closed, and Discussed
List of Acronyms
List of Documents Reviewed

PARTIAL LIST OF PERSONNEL CONTACTED

Beaver Valley

R. Bisbee	Administrator, Corrective Action Program
R. Brosi	Manager, Work Management System
T. Cosgrove	Manager, Regulatory Affairs
R. Ferrie	System Engineer
L. Freeland	Manager, Nuclear Services
J. Freels	Manager, Engineering Technical Support
M. Gilloory	Nuclear Tech. Corrective Actions
K. Grada	Manager, Outage Management
K. Halliday	Manager, Configuration Management
R. Hansen	Manager, Quality Assurance
L. Meyers	Vice President, Nuclear
R. Miller	Lead, Nuclear Engineering
G. Oakley	Manager, Planning and Scheduling
S. Oberlitner	Intern, Corrective Action
L. Pearce	Plant General Manager
M. Pearson	Director, Nuclear Services
D. Reeves	Supervisor, Maintenance Engineering
R. Rossomme	Supervisor, Nuclear Quality Assurance
L. Ryan	DEP/BRP
B. Sepelak	Supervisor, Regulatory Affairs
S. Vicinie	Manager, Emergency Preparedness

NRC

D. Kern	Senior Resident Inspector
D. Lew	Chief, Performance Evaluation Branch, DRS
G. Wertz	Resident Inspector

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened & Closed

50-334,412/01-011-01	NCV	Failure to evaluate test failures associated with two molded case circuit breakers to prevent recurrence.

LIST OF ACRONYMS

BV	Beaver Valley
CAQ	Condition Adverse to Quality
CARB	Corrective Action Review Board
CFR	Code of Federal Regulations
CR	Condition Report
CRP	Condition Report Process
gpm	Gallons per Minute
IR	Inspection Report
MCCB	Molded Case Circuit Breaker
NCV	Non-Cited Violation
NQAC	Condition Not Averse to Quality
NRC	Nuclear Regulatory Commission
QA	Quality Assurance
RSS	Recirculation Spray System
SCAQ	Significant Condition Adverse to Quality
SDP	Significance Determination Process

LIST OF DOCUMENTS REVIEWED

PROCEDURES

1/2CMP-01RDS-MG-01E	Generator Bearing Replacement
1/2CMP-75-MCB-2E	Testing of ITE 480 Volts Molded Case Circuit Breakers
1/2PMP-E-36-001	4KV Bus Switchgear Inspection
1/2PMP-E-36-015	ITE Medium Voltage Circuit Breaker Inspection and Test
1/2PMP-E-37-010	ITE Low Voltage Circuit Breaker Inspection and Test
1/2PMP-E-37-011	480 Volt Linestarter Inspection
1OST-24.9	Turbine-Driven AFW Pump Operability Test
1OST-36.1 & 1OST-36.2	Diesel Generator Monthly Tests
2OST-6.7	Accident Monitoring Instrumentation Channel Checks
1PMP-E-37-011	GE Model AK-3A & 7A-25 Ckt Breaker Inspection and Test
1PMP-E-37-012	GE Model AK-3A-50S &AKS-7A-50 Ckt Breaker Inspection & Test
1PMP-37-SS-Linestarter-2E	Linestarter Inspection
1PMP-39DC-BKR-1E	Battery Air Circuit Breaker Inspection GE AK-2A-25
2PMP-E-39-013	ITE Low Voltage DC Circuit Breaker Inspection and Test
2PMP-13-RSS-FILL-1A-I	Filling & Venting of Train A RSS Pump Flow Transmitter
NOP-LP-2001	Condition Report Process and Reference Guide
NPDAP 5.7	Basis for Continued Operation
NPDAP 7.5	Processing a Work Request
NADAP7.12	Non-Outage Planning , Scheduling, and Risk Assessment
NPDAP 8.12	Control And Coordination of Technical Specification Surveillances
OMDG-002	Operations Work Arounds / Control Room Deficiencies
SPEAP 1.11	System And Performance Engineering Administrative Manual
SPEAP 3.2	Maintenance Rule (a)(1) Disposition Review (Various)
---	Root Cause Analysis Reference Guide

CONDITION REPORTS

98-1553	00-2622	00-3033	00-3263	00-3644
00-0228	00-2628	00-3131	00-3266	00-3669
00-1453	00-2648	00-3135	00-3335	00-3682
00-1995	00-0657	00-3139	00-3361	00-3706
00-2262	00-2680	00-3153	00-3302	00-3723
00-2333	00-2683	00-3158	00-3390	00-3741
00-2340	00-2693	00-3160	00-3392	00-3791
00-2360	00-2719	00-3166	00-3431	00-3835
00-2383	00-2751	00-3185	00-3465	00-3856
00-2460	00-2752	00-3193	00-3483	00-3827
00-2462	00-2753	00-3195	00-3512	00-3858
00-2470	00-2765	00-3203	00-3519	00-3870
00-2476	00-2808	00-3236	00-3524	00-3878
00-2540	00-2817	00-3238	00-3534	00-3903
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01-3461
01-3887
01-4134
01-4235
01-4312
01-4549
01-4571

Work Orders

96-053027	Incore Thermocouple
98-068942	Emergency Diesel Engine Oil Leak
99-078251	Temperature Element 2RCS-TE04E
99-078317	Temperature Element 2RCS-TE32E
99-221370	Neutron Flux Recorder
00-008322	PRZR PORV Relief VLV
00-013179	Pressurizer Level Channel Recorder Selector
00-019212	Corrosion on Quench Spray Pump 2QSS-P21B
00-020161	Temperature Element 2RCS-TE26E
00-025722	Temperature Element 2RCS-TE19E
00-025724	Temperature Element 2RCS-TE15E
00-027529	Audio Monitor Signal Amplifier/Condition
01-007923	Turbine Driven Aux Feed Pump 2FWE-P22
01-010215	Quench Spray Pump 21A Seals

NON-CITED VIOLATIONS

2000-009-01	Failure to Implement Timely and Effective Corrective Actions
2000-010-01	Operators Failed to Implement Technical Specifications Actions
2000-012-01	Corrective Maintenance 2RCS-557B
2000-014-01	Inadequate Emergency Procedure Guidance
2001-002-03	Failure to Follow Plant Shutdown Procedures

SELF-ASSESSMENTS & THIRD PARTY EVALUATIONS

SA-00-08	Security Officer Training
SA-00-26	Operations Department Pre-Job Briefings
SA-01-33	NDE Compliance
SA-00-38	Operator Training Records
SA-01-63	PM Program Effectiveness of Improvements From CR 99-3202
SA-01-65	Corrective Action Effectiveness

QUALITY ASSURANCE AUDITS & SURVEILLANCES

BV-C-00-08	Audit of Nonconformance Control and Corrective Action Program

ROOT CAUSE ANALYSES

CR 00-3956	TERs Not Fully Incorporated
CR 00-3975	Technical Evaluation Report - Closeout Process Weaknesses

OTHER DOCUMENTS

1/2OM-48.6.A.102	ESF Mimic Print
10080-RM-413-1	Recirculation Spray System Flow Diagram
12241-LSK-27-1C	Logic Diagram Recirculation Spray System
2BVT 1.13.5	Recirculation Spray Pump Test
B-241821	Universal Venturi Tube
EM 102497	2RSS-FT157A, B, C, & D Sensing Lines
EM 200714	Frequency Change Request for Performing 1/2PMP-13-RSS-FILL-1A-I
RSS-10-3-C	Setpoint of 2RSS*FSL157C & D Low Flow

SP-2RSS-10	Setpoint for 2RSS*FSL157 C & D
---	River Water Latent Issues Report
---	Latent Issues System Project Plan